Health and Human Services System Strategic Plan 2009–13

Volume I

Health and Human Services Commission

Department of Aging and Disability Services

Department of Assistive and Rehabilitative Services

Department of Family and Protective Services

Department of State Health Services

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Foreword

House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, consolidated the 12 health and human services agencies into the following five agencies:

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

H.B. 2292 also established a clear structure for these agencies to form the Health and Human Services System (HHS System), interchangeably known as the HHS Enterprise. Accordingly, this Plan consolidates the strategic plans for all agencies in the HHS System into one document. Chapters I-IV address planning involving System-wide elements, including the Historically Underutilized Business Plan. Chapters V-IX are the agencies' individual Strategic Plans, and Chapter X includes the goals, objectives, and strategies for all agencies, in accordance with State strategic planning guidelines. In addition, several of the required appendices are written from a systems perspective:

- Appendix A—Description of Planning Process,
- Appendix E— Information Resources Strategic Plan
- Appendix F— Health and Human Services Enterprise Workforce Plan,
- Appendix G—Survey of Organizational Excellence, and
- Appendix H—Workforce Development System Strategic Planning.

Meeting Multiple Requirements

The Texas Government Code, §531.014, CONSOLIDATION OF REPORTS, grants the HHS Executive Commissioner the authority to consolidate reports. Accordingly, this consolidated plan addresses the following requirements:

- **Strategic plan—**required of each state agency, by Texas Government Code, Chapter 2056, STRATEGIC PLANS OF OPERATION;

- **Coordinated Strategic Plan—**required by Texas Government Code, Section 531.022, COORDINATED STRATEGIC PLAN FOR HEALTH AND HUMAN SERVICES; and
- **Historically Underutilized Businesses (HUB) Plan—**required as part of each strategic plan, by Texas Government Code, Section 2161.123, STRATEGIC PLANNING, and presented in Chapter IV, HHS System Ongoing State Planning Requirements and Initiatives.

Fiscal Year Terminology

In this Plan, the term "fiscal year" means state fiscal year, from September 1 of a year through August 31 of the following year. It is spelled out the first time it is used in each chapter, and it is abbreviated "FY" through the rest of the chapter.

The term "federal fiscal year" is used to specify the federal budget period, from October 1 of a year through September 30 of the following year. It is spelled out the first time it is used in each chapter, and it is abbreviated "FFY" through the rest of the chapter.

Terminology for Demographic Groups

In this Plan, the demographic terminology used is the same as the terminology used by the Texas State Data Center (SDC), with the exception that this Plan uses "African American" where the SDC uses "Black." Accordingly, the following terms have the following meanings:

- **Anglo—**White, non-Hispanic,
- **Hispanic—**Cultural identification, including any race;
- **African American—**Black, non-Hispanic, and
- **All other population groups combined—**All racial/ethnic groups not included in the categories above, with examples including Chinese, Vietnamese, Native American, Eskimo, and others.

Visual Accessibility

For greater visual accessibility, this Strategic Plan has been printed in Arial 12-point font. Readers with visual impairments may find it useful to know the following:

- Bullet format uses “wingdings062,” as illustrated here; and
- Footnotes are used for references and occasional notes.

The Plan is available on-line in an accessible format, at the following website:

http://www.hhs.state.tx.us\StrategicPlans\HHS09-13\StrategicPlan_FY2009-2013.pdf.

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Texas Health and Human Services System Strategic Plan for 2009-13

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Chapter I

Statewide Vision, Mission, and Philosophy

Introduction

The cycle of strategic planning and budgeting began in Texas in 1992 with the issuance of a statewide vision. Health and Human Services (HHS) System agencies have developed strategic plans every two years since 1992 and the Coordinated Strategic Plan every two years since 1996.

House Bill 2292, 78th Legislature, Regular Session, 2003, dramatically changed the landscape of health and human services agencies in Texas. This plan reflects those changes and is the result of strategic thinking about the future of health and human services in Texas as a system, rather than as 12 separate, yet coordinated entities. It provides a common direction for the system and an understanding of the five agencies that comprise it:

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

This plan is grounded in the Statewide Vision, Mission, and Philosophy developed by the Governor and the Legislative Budget Board and presented below.

Statewide Vision—Securing Our Future

Working together, I know we can address the priorities of our citizens. As my administration works to create greater opportunity and prosperity for our citizens, making our state and its people truly competitive in the global marketplace, we must remain focused on the following critical priorities:

- *Assuring open access to an educational system that not only guarantees the basic core knowledge necessary for productive citizens but also emphasizes excellence and accountability in all academic and intellectual undertakings;*
- *Creating and retaining job opportunities and building a stronger economy to secure Texas' global competitiveness, leading our people and a stable source of funding for core priorities;*
- *Protecting and preserving the health, safety, and well-being of our citizens by ensuring healthcare is accessible and affordable and by safeguarding our neighborhoods and communities from those who intend us harm; and*
- *Providing disciplined, principled government that invests public funds wisely and efficiently.*

Rick Perry
Governor of Texas

The Mission of Texas State Government

Texas state government must be limited, efficient, and completely accountable. It should foster opportunity and economic prosperity, focus on critical priorities, and support the creation of strong family environments for our children. The stewards of the public trust must be men and women who administer state government in a fair, just, and responsible manner. To honor the public trust, state officials must seek new and innovative ways to meet state government priorities in a fiscally responsible manner.

The Philosophy of Texas State Government

The task before all state public servants is to govern in a manner worthy of this great state. We are a great enterprise, and as an enterprise we will promote the following core principles:

- First and foremost, Texas matters most. This is the overarching, guiding principle by which we will make decisions. Our state, and its future, is more important than party, politics, or individual recognition.
- Government should be limited in size and mission, but it must be highly effective in performing the tasks it undertakes.
- Decisions affecting individual Texans, in most instances, are best made by those individuals, their families, and the local governments closest to their communities.

- Competition is the greatest incentive for achievement and excellence. It inspires ingenuity and requires individuals to set their sights high. Just as competition inspires excellence, a sense of personal responsibility drives individual citizens to do more for their future and the future of those they love.
- Public administration must be open and honest, pursuing the high road rather than the expedient course. We must be accountable to taxpayers for our actions.
- State government has a responsibility to safeguard taxpayer dollars by eliminating waste and abuse, and providing efficient and honest government.
- Finally, state government should be humble, recognizing that all its power and authority is granted to it by the people of Texas, and those who make decisions wielding the power of the state should exercise their authority cautiously and fairly.

Statewide Goals and Benchmarks for Health and Human Services

The HHS System addresses all of the statewide benchmarks identified for HHS System agencies. The HHS System also contributes significantly to the Regulatory priority goal, and to a lesser extent, to the success of the General Government and Education—Public Schools priority goals.

Health and Human Services Priority Goal: Benchmarks by Agency

To promote the health, responsibility, and self-sufficiency of individuals and families by:

- *Making public assistance available to those most in need through an efficient and effective system;*
- *Restructuring Medicaid funding to optimize investments in health care and reduce the number of uninsured Texans through private insurance coverage;*
- *Enhancing the infrastructure necessary to improve the quality and value of health care through better care management and performance improvement incentives;*
- *Continuing to create partnerships with local communities, advocacy groups, and the private and not-for-profit sectors;*
- *Investing state funds in Texas research initiatives which develop cures for cancer; and*
- *Addressing the root causes of social and human service needs to develop self-sufficiency of the client through contract standards with not-for-profit organizations.*

HHSC

The HHSC strategies listed in Chapter X address the following statewide benchmarks:

- Percent of Texas population enrolled in Medicaid, Children's Health Insurance, and the Health Insurance Premium Payment programs;
- The number and rate of uninsured Texans;
- Average amount recovered and saved per completed Medicaid provider investigation;
- Percent of eligible children enrolled in CHIP;
- Percent of Texans receiving TANF cash assistance;
- Percent of adult welfare participants in job training who enter employment;
- Percent of Texas population receiving food stamps;
- Number of Texans using call centers to apply for Medicaid, food stamps, and other state services; and

DADS

The DADS strategies listed in Chapter X address the following statewide benchmarks:

- Percent of long-term care clients served in the community; and
- Incidence of confirmed cases of abuse, neglect, or death of children, the elderly, or spouses per 1,000 population.

DARS

The DARS strategies listed in Chapter X address the following statewide benchmarks:

- Percent of population under age 3 years served by the Early Childhood Intervention Program; and
- Percent of people completing vocational rehabilitation services and remaining employed.

DFPS

The DFPS strategies listed in Chapter X address the following statewide benchmarks:

- Average daily caseload for Child Protective Services;
- Average daily caseload for Adult Protective Services;
- Incidence of confirmed cases of abuse, neglect, or death of children, the elderly, or spouses per 1,000 population; and
- Percent of children in foster care who are adopted or reunited with their families.

DSHS

The DSHS strategies listed in Chapter X address the following statewide benchmarks:

- Number of children served through the Texas Health Steps Program;
- Percent of Texas children in kindergarten who are completely immunized according to school immunization requirements;
- Infant mortality rate;
- Low birth-weight rate;
- Teen pregnancy rate;
- Percent of births that are out-of-wedlock;
- Number of women served through Title V prenatal care services;
- Percent of screened positive newborns who receive timely follow-up (Title V newborn screening);
- Rate of substance abuse and alcoholism among Texans;
- Number of methamphetamine prevention / awareness programs related to methamphetamine production and child welfare conducted by the Texas Department of State Health Services;
- Number of women served through the Texas Breast and Cervical Cancer Program;
- Readiness score by the CDC on the state Antiviral Allocation, Distribution and Storage Plan;
- Number of Federally Qualified Health Centers (FQHCs) since the inception of the Texas FQHC Incubator Program;
- Number of people who receive mental health crisis services at community mental health centers;
- Number of state funded cancer research grant projects; and
- Amount of leveraged dollars invested in state funded research grant projects.

Regulatory Priority Goal: Benchmarks by Agency

To ensure Texans are effectively and efficiently served by high-quality professionals and businesses by:

- *Implementing clear standards;*
- *Ensuring compliance;*
- *Establishing market-based solutions; and*
- *Reducing the regulatory burden on people and business.*

DADS

The DADS strategies listed in Chapter X address the following statewide benchmarks:

- Percent of state professional licensee population with no documented violations;
- Percent of new professional licensees as compared to the existing population;
- Percent of documented complaints to professional licensing agencies resolved within six months;
- Percent of individuals given a test for professional licensure who received a passing score; and
- Percent of new and renewed professional licenses issued via Internet.

DFPS

The DFPS strategies listed in Chapter X address the following statewide benchmarks:

- Percent of state professional licensee population with no documented violations;
- Percent of new professional licensees as compared to the existing population;
- Percent of documented complaints to professional licensing agencies resolved within six months;
- Percent of individuals given a test for professional licensure who received a passing score; and
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DSHS

The DSHS strategies listed in Chapter X address the following statewide benchmarks:

- Percent of state professional licensee population with no documented violations;
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- Percent of documented complaints to professional licensing agencies resolved within six months;
- Percent of individuals given a test for professional licensure who received a passing score; and
- Percent of new and renewed professional licenses issued via Internet.

Chapter II

Health and Human Services System and Agency Overviews

Health and Human Services System

For almost 150 years the State of Texas has been providing health and human services for its citizens, initially serving those who were blind or deaf and hard of hearing and those with mental illness. From those early beginnings the state's efforts in providing health and human services have grown to account for approximately one-third of state spending or approximately $52.2 billion per biennium (all funds). Services are provided to millions of Texans with these dollars and through the efforts of approximately 48,000 state employees operating more than 200 programs from more than 1,000 locations around the state.

The tremendous growth of the state's health and human services programs occurred over many decades in a piecemeal fashion and without the benefit of an overall plan. By 2003, the services were provided through an array of 12 largely independent state agencies, producing undue complexity for staff and service providers as well as clients and consumers. Redundancies and inefficiencies in this disjointed system also increased administrative and operational costs.

Facing this situation, the 78th Legislature passed House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, creating an unprecedented mandate and opportunity to comprehensively redesign and transform the administration and delivery of health and human services. Most notably, H.B. 2292 provided a roadmap to consolidate the 12 agencies into a 5-agency system, with the Health and Human Services Commission (HHSC) receiving increased responsibility and authority for providing guidance, coordination, and leadership for the system. HHSC was also made responsible for the centralization of most of the administrative support functions that had been provided separately by most of the 12 former agencies.

The consolidation of the agencies was accomplished by September 1, 2004, with the commencement of operations by the Department of State Health Services (DSHS) and the Department of Aging and Disability Services (DADS). They joined HHSC, the Department of Family and Protective Services (DFPS), and the Department of

Assistive and Rehabilitative Services (DARS) in comprising the five-agency Health and Human Services (HHS) System that exists today.

The consolidation of agencies, and all other efforts to transform the HHS System, has been guided by three key principles adopted by the Transition Legislative Oversight Committee in a plan to achieve the vision of H.B. 2292.

A Focus on Client Needs and Program Delivery—Realigning programs around the people we serve.

Effective Stewardship of Public Resources—Streamlining administrative operations and redirecting savings into services.

Cultural Change and Accountability—Changing the organizational culture to a single-entity, outcome-based philosophy across the entire system and strengthening accountability to the taxpayer.

Now, five years after the passage of H.B. 2292, much progress has been made in creating a transformed HHS System. As these planning documents make clear, though more remains to be done in furthering the transformation of the HHS System and in responding to the dynamic circumstances and evolving issues faced in delivering health and human services that meet the needs of the citizens of Texas.

HHS System Vision

Albert Hawkins, Executive Commissioner for the HHS System, has articulated the following System vision:

> *We envision a health and human services system that works better and costs less. Toward this goal, we will seek input and build partnerships with local governments, advocacy groups, and community-based organizations to develop a system that is rationally organized, effectively managed, accountable for results, and most importantly, centered on the needs of clients. This will allow our employees to focus on what they do best—helping Texans in need.*

HHS System Mission

The mission of health and human services agencies in Texas is to develop and administer an accessible, effective, efficient health and human services delivery system that is beneficial and responsive to the people of Texas.

HHS System Philosophy

Every Texan should be able to access and utilize available health and human services provided by state agencies in the most integrated, cost-effective setting possible. The Texas HHS System is dedicated to developing client-focused program and policy initiatives that are relevant, timely, and within the means of the taxpayers of the State of Texas. The HHS System will advocate for client-choice, appropriate funding, and streamlined service delivery. Additionally, we hold to these guiding principles:

> Every person, regardless of income, race, ethnicity, physical or mental limitation, gender, religion, or age, is entitled to dignity, independence, and respect.
>
> Texans deserve openness, fairness, and the highest ethical standards from us, their public servants.
>
> Taxpayers, and their elected representatives, deserve conscientious stewardship of public resources and the highest level of accountability.
>
> As agency representatives, we work in partnership with lawmakers, agency personnel, customers, service providers, and the public to continually improve the quality of our services.

HHS leadership understands its direct accountability to the taxpayers, elected representatives, federal agencies, and, most importantly, customers and clients of the system. We seek to achieve our goals and objectives with a “single-entity, outcome-oriented” philosophy, viewing the HHS agencies as a unified organization with common goals and shared resources.

HHS System Strategic Goals

The following system strategic goals provide a unifying focus for the HHS System.

> ***Preserve, enhance, and maintain independence—***-enable the aging, and people with disabilities, including those with mental retardation and other developmental conditions, to live as independently as possible for as long as possible through an effective, individualized system of service provision in community and institutional settings.
>
> ***Promote and protect good health—***protect public health and promote the overall physical and mental health of Texans through the provision of education, early intervention, substance abuse treatment, health insurance, and appropriate health services for eligible populations.

Achieve economic self-sufficiency—enable low-income individuals and the clients of family violence, refugee, and vocational rehabilitation programs to achieve self-sufficiency for themselves and their families by providing needed income assistance and/or related support services on a temporary basis.

Ensure safety and dignity—ensure safety and protection of children and adults from abuse, neglect, or exploitation through comprehensive regulatory and enforcement systems that include certification, training, and assistance to health care and child care providers and personnel.

HHS System Organizational Structure

Reflecting the unified philosophy and approach to delivering health and human services, the HHS System agencies operate with similar organizational structures. These organizational structures reflect emphases on efficiency, service delivery, and providing visible and accessible agency resources for stakeholders. Similarly, each agency has an agency council created under H.B. 2292 and an internal audit office with direct accessibility to the agency Commissioner. The organizational charts for all five HHS System agencies are presented in Appendix B.

The following sections provide each agency's vision, mission, scope, and structure.

Health and Human Services Commission

Vision

Through the Texas Health and Human Services Commission's strategic direction and leadership, we envision a coordinated health and human services system that ensures quality services, cost-effective service delivery, and careful stewardship of public resources. HHSC will direct and support collaboration and partnerships of agencies with consumers and local communities to establish systems that support individual choices and personal responsibility.

Mission

The mission of the Health and Human Services Commission is to provide leadership and direction and foster the spirit of innovation needed to achieve an efficient and effective health and human services system for Texans.

Scope

Originally created in 1991 to provide strategic leadership to all HHS System agencies, HHSC now oversees the operations and policies of the entire HHS System in Texas, and HHSC directly operates the Medicaid program, the Children's Health Insurance Program (CHIP), and several family support programs. HHSC also operates a consolidated eligibility determination function for several major programs of the HHS System. HHSC provides consolidated or coordinated administrative support for all HHS System agencies. Thus, HHSC has responsibilities as a leadership, operational, and oversight agency. The agency is accountable to Texans for ensuring that the HHS System provides quality services in the most efficient and effective manner possible.

Structure

An Executive Commissioner appointed by the Governor and confirmed by the Senate leads HHSC. Albert Hawkins has served as the Executive Commissioner since December, 2002.

HHSC is organized along the divisional lines listed below. The System Oversight divisions work together to provide support and direction to the System departments in implementing legislation, streamlining services, and facilitating cross-agency innovation. The Commission's Operations divisions are responsible for HHSC programs and administrative functions.

System Oversight

- Chief of Staff
- Chief Counsel
- Inspector General
- Social Services
- Financial Services
- System Support Services
- Health Services

Commission Operations

- General Counsel
- Internal Audit
- Chief Operating Officer
- Chief Financial Officer
- External Relations
- Family Services

- Eligibility Services
- Medicaid/CHIP

Department of Aging and Disability Services

Vision

Older Texans and persons with disabilities will be supported by a comprehensive and cost-effective service delivery system that promotes and enhances individual well-being, dignity, and choice.

Mission

The DADS mission is to provide a comprehensive array of aging and disability services, supports, and opportunities that are easily accessed in local communities.

Scope

On September 1, 2004, DADS began operation. The Department provides a continuum of long-term services and supports which are available to eligible older Texans, individuals with physical disabilities, and individuals with intellectual or developmental disabilities. In addition, DADS licenses and regulates providers of these services.

Structure

The HHSC Executive Commissioner, with approval of the Governor, appoints the DADS Commissioner. The agency is divided into the following programmatic and support divisions that report to the Commissioner:

- Internal Audit;
- Deputy Commissioner;
- Access and Intake;
- Provider Services;
- Regulatory Services;
- Chief Financial Officer; and
- Chief Operating Officer.

Department of Assistive and Rehabilitative Services

Vision

A Texas where people with disabilities and families with children who have developmental delays enjoy the same opportunities as other Texans to pursue independent and productive lives.

Mission

To work in partnership with Texans with disabilities and families with children who have developmental delays to improve the quality of their lives and to enable their full participation in society.

Scope

DARS administers programs that ensure Texas is a state where people with disabilities and children with developmental delays enjoy the same opportunities as other Texans to live independent and productive lives. The Department has four program areas: Rehabilitation Services, Blind Services, Early Childhood Intervention Services, and Disability Determination Services. Through these program areas, DARS provides services that help Texans with disabilities find jobs through vocational rehabilitation, ensure that Texans with disabilities live independently in their communities, and help children with disabilities and developmental delays reach their full potential.

Structure

The HHSC Executive Commissioner, with approval of the Governor, appoints the DARS Commissioner. The agency is divided in the following programmatic and support divisions that report to the Commissioner:

- Internal Audit;
- Deputy Commissioner;
- Rehabilitation Services (includes the Office of Deaf and Hard of Hearing Services);
- Blind Services;
- Early Childhood Intervention Services;
- Chief Financial Officer; and
- Chief Operating Officer.

Department of Family and Protective Services

Vision

DFPS is an agency that:

- Delivers effective, efficient, and innovative client services that are nationally recognized for excellence;
- Supports its staff, who are highly motivated, well prepared for their jobs, exhibit a strong sense of professionalism, and enjoy their work;
- Builds strong, effective, and mutually valued partnerships with clients, communities, and state leadership; and
- Provides effective leadership that is accountable for its actions and communicates openly with clients and stakeholders.

Mission

The mission of DFPS is to protect children, the elderly, and people with disabilities from abuse, neglect, and exploitation by working with clients, families, and communities.

Scope

DFPS began operations on February 1, 2004. DFPS continues the work of the legacy Department of Protective and Regulatory Services to protect children, adults who are older persons or have disabilities and are living at home or in state facilities, and to license day-care homes, day-care centers, and registered family homes. DFPS also manages community-based programs that prevent delinquency, abuse, neglect, and exploitation of Texas children.

Structure

The HHSC Executive Commissioner, with the approval of the Governor, appoints the DFPS Commissioner. DFPS is divided into operational and support divisions that work in concert to allow the agency to accomplish its mission of providing services to the state's most vulnerable citizens. Those divisions are listed here:

- Internal Audit;
- Deputy Commissioner;
- Adult Protective Services;
- Child Protective Services;

- Child Care Licensing;
- Purchased Client Services;
- Chief Financial Officer; and
- Chief Operating Officer.

Department of State Health Services

Vision

A Healthy Texas

Mission

To improve health and well-being in Texas

Scope

The agency administers and regulates public health and behavioral health programs.

Structure

The HHSC Executive Commissioner, with the approval of the Governor, appoints the DSHS Commissioner. The following areas of the agency report to the Commissioner:

- Internal Audit;
- Deputy Commissioner;
- Associate Commissioner;
- Chief Operating Officer.
- Chief Financial Officer;
- State Epidemiologist;
- State Medical Director for Behavioral Health;
- Mental Health and Substance Abuse Services;
- Regulatory Services;
- Regional and Local Health Services;
- Family and Community Health Services; and
- Prevention and Preparedness Services.

Chapter III

Health and Human Services System External/Internal Assessment

Strategic Priorities

Each of the state's five health and human services agencies is a large and complex operation providing critical services to countless numbers of Texans. The agency-specific chapters of this plan provide detail on the myriad of challenges and opportunities faced by each agency and on many important activities and initiatives that are ongoing or planned in fulfilling each agency's mission. This section provides an overview of several of the strategic priorities facing the Health and Human Services (HHS) Enterprise.

Two other topics which also rank as strategic priorities are addressed as adjuncts to this document, pursuant to legislative requirements. Successful operation of organizations as critical, large, and complex as the HHS Enterprise is heavily dependent on information technology (IT) systems. While over the years the state has made large investments in IT systems supporting the provision of health services and human services, the scope and complexity of the HHS Enterprise necessitates an ongoing pattern of large investments in IT. Technology investments are needed to:

- Maintain, modernize, or extend the life of legacy information systems;
- Support improved services and business practices;
- Achieve efficiencies;
- Comply with new federal and accreditation requirements; and
- Meet the changing needs and expectations of Texans.

A full discussion of IT needs and the direction of the HHS Enterprise is provided in Appendix E, the Information Resources Strategic Plan.

The HHS Enterprise faces serious challenges in recruiting and retaining an adequate workforce in several respects. For example, high turnover rates make it difficult to develop and maintain a workforce of sufficient size and experience in such areas as direct care, protective services, and eligibility. Keeping nurse, physician,

and pharmacist positions filled is another key challenge, as is sustaining a workforce with sufficient levels of specialized expertise in areas such as information technology (IT) and regulatory programs. Issues relating to the workforce of the HHS Enterprise are discussed in Appendix F, the Health and Human Services System Workforce Plan for Human Capital Management.

Keeping Pace with Service Demands and Costs

Consistent with national trends, HHS System programs continue to face short-term and long-term challenges in meeting increasing demands for and costs of services. One factor that would affect the cost of services, even if the population were not growing, is inflation. In recent years, medical cost inflation has been the primary type of cost pressure faced by health and human services agencies, because medical costs have risen steadily while the rate of general inflation remained low. In part, the medical cost trends have been due to the availability of new treatments and technologies, and to the advent of new drugs which are often more effective but also more expensive. The patterns in which the population uses medical services also affect costs, and costs will increase, even in the absence of population growth, if the average person uses more services or more expensive services. While the pattern of continuing increases in the cost of medical services is likely to continue, health and human services agencies are now facing broader cost pressures in terms of such necessities as food, fuel, and utilities.

As noted later in this chapter, Texas is in a sustained pattern of population growth. Consequently, in Texas the cost pressures from inflation and service utilization increases will be coupled with the greater demand for services that comes with a growing population. Within the overall trend of sustained population growth, a more specific demographic trend, of critical importance in relation to the demand for and cost of health and human services, is the aging of the population. The average age of the population in Texas, as in the rest of the country, will increase markedly in coming decades, and the number of persons more than 65 years of age will increase faster than the population as a whole. Because these older adults more heavily utilize medical and long-term care services, the aging of the population will be another source of pressure on the HHS System's programs. Additionally, the aging of the population will reduce the ratio of informal care givers (usually family members) to persons requiring long-term care, thereby further increasing the demand for publicly funded services.

Another factor of major importance within the overall trend of a growing population is the changing ethnic and racial composition of the population. Within the Texas population there are disparities among racial and ethnic groups in terms of economic status and health status that, in turn, relate to differences in the patterns and levels of use of HHS System programs. These disparities indicate areas in need of targeted attention within the HHS System, and they indicate which types of issues or situations may become more prevalent in the coming decades.

The factors of inflationary cost pressures, service utilization trends, changes in the size, age profile, and racial and ethnic composition of the population, and health disparities among these groups, will broadly affect the HHS Enterprise. As a result, these factors are discussed in numerous places in this planning document. In conjunction with these factors, trends in the economy and the availability of privately funded health insurance are also discussed as factors of critical importance in terms of the demand for publicly funded health and human services.

Expanding Services to Address Interest Lists and Waiting Lists

A perennial challenge facing some HHS System programs is meeting the demand for services. For some programs, when the demand for services exceeds the services available, most often due to funding constraints, individual names are placed either on an interest list based on an expression of interest in receiving services or on a waiting list indicating that the individual is ready to begin receiving services and is definitely eligible for services. Those program-specific lists record and date an individual's interest in or application for services, and there is most commonly a priority order for the next individuals to receive services as opportunities become available.

By far the most substantial of these lists are the interest lists for community-based Medicaid services provided by the Department of Aging and Disability Services (DADS). DADS programs had the following interest lists as of December 31, 2007:

- Home and Community-Based Services—34,947 individuals;
- Community Based Alternatives—31,470 individuals;
- Community Living Assistance and Support Services—18,684 individuals;
- Medically Dependent Children's Program—8,484 individuals;
- STAR+PLUS—8,783 individuals; and
- Deaf/Blind with Multiple Disabilities—25 individuals.

DADS' interest lists for Medicaid services totaled 102,393 individuals on December 31, 2007, with an unduplicated count of 86,751 individuals.

The Department of State Health Services (DSHS) and the Department of Assistive and Rehabilitative Services (DARS) have waiting lists. In March 2008, DSHS had waiting lists for Adult Mental Health Services (3,600 individuals), Children's Mental Health Services (412 individuals), and Children with Special Health Care Needs Services Program (1,053 individuals). DARS had waiting lists of 989 individuals for the Independent Living Services program and 56 individuals for the Comprehensive Rehabilitation Services program.

These substantial interest lists and waiting lists continue to exist despite expanded state investments in addressing such lists in the last two legislative sessions. In relation to DADS, for the 2006-07 biennium, the 79th Legislature provided funds to reduce interest lists by making it possible to serve an additional 9,360 individuals in the Medicaid waiver programs and non-Medicaid services. For the 2008-09 biennium, funding was provided to serve an additional 8,595 of those individuals, of whom 4,993 are in Medicaid waiver programs. DSHS received appropriations for the 2008-09 biennium to address its waiting lists by adding capacity to serve an additional 646 children with special health care needs and by adding capacity to serve an additional 288 children needing mental health services. DARS received appropriations that allowed it to eliminate, by the end of fiscal year (FY) 2007, a list of 183 individuals awaiting comprehensive rehabilitation services for traumatic brain and spinal cord injuries, and a list of 173 additional individuals to be served with independent living services to prevent growth in that waiting list.

The continued existence of sizable interest lists and waiting lists for programs in the HHS System clearly illustrates the need for further substantial investments in these services. Even with the recent progress in expanding services, these lists do not necessarily decline in size, due to several factors. These factors include population growth, changing demographics (such as an aging population) that affect the demand for services, and the phenomenon that public awareness of expanding services sometimes encourages people who had given up hope of the availability of services to express an interest in receiving services. Nevertheless, regardless of how fast or whether the interest lists or waiting lists are reduced as services are expanded, additional investments in expanding services will greatly improve the health and quality of life of many more Texans with these critical needs.

Infrastructure Needs at State-Operated Direct Care Facilities

The HHS Enterprise encompasses 23 state-operated facilities within its vast array of responsibilities. The 12 DADS-operated facilities for individuals with mental retardation provide residential and health care services on a long-term basis for approximately 4,900 individuals each day. One facility, the Rio Grande State Center, is operated by DSHS and provides both mental health and mental retardation services. Eight state mental health facilities and the Waco Center for Youth are operated by DSHS and provide inpatient psychiatric care to more than 2,300 persons each day. DSHS also operates the Texas Center for Infectious Disease, which provides treatment for tuberculosis (TB) and Hansen's disease, also known as leprosy. In sum, the state is directly responsible for providing for all daily living needs of approximately 7,200 individuals and for addressing the often acute or profound specialized needs of the individuals under its direct care.

An ongoing challenge is adequately maintaining the physical infrastructure of the facilities essential to the quality of care and quality of life of individuals receiving

services at those facilities. The cost of maintaining, repairing, and renovating those facilities is substantial and requires ongoing investments. The need for substantial and ongoing capital investments is driven by the sheer size of these two systems of care and the fact that most of the 1,401 buildings at these facilities are quite old. Most of the needs are very basic and essential, such as critical Life Safety Code improvements, and repairs to roofing, air conditioning, heating and electrical systems.

In recent years, the Legislature has notably increased its level of reinvestment in these facilities by appropriating a combined total of approximately $48.0 million in bond funds for construction, renovation, and repairs for the 2006-07 biennium, and approximately $70.4 million in bond funds for those purposes for the 2008-09 biennium. The ongoing demand for services, coupled with the increasing age of these facilities, ensures a continuing need for substantial reinvestments to meet accreditation/certification standards and the commitment to providing high quality care and a good quality of life for individuals who require the services of these facilities.

The DSHS and DADS chapters of this document also extensively address another area of need related to the infrastructure of the direct care facilities. Funding for the replacement of vehicles at these facilities has been very limited for several biennia. Many of the vehicles for transporting clients and the vehicles for facility support are now very old and in serious need of replacement, to ensure clients are transported safely and that the facilities operate efficiently and without disruptions.

Modernizing Eligibility Determination Processes

Determining eligibility for services is a critical component of delivering state health and human services. Approximately 6,700 Health and Human Services Commission (HHSC) employees, representing more than 10 percent of the total HHS Enterprise positions, are devoted exclusively to determining eligibility for HHS System programs. Hundreds of other employees and major information systems support the eligibility determination processes.

The eligibility determination workload is immense. The HHS System agencies operate programs serving more than 6 million clients per year, with 3.8 million active cases in any given month. Eligibility workers complete approximately 300,000 applications and 1.1 million renewal determinations per month, or approximately 3.6 million applications and 13.8 million renewal determinations per year.

Eligibility criteria differ for the major programs in the HHS System: Medicaid, the Children's Health Insurance Program (CHIP), Food Stamps, Temporary Assistance for Needy Families (TANF), and Long-Term Care. Since 1978, these programs have relied on a common automated case management system. Eligibility is determined for each program separately, a situation that often requires eligibility

workers to enter the same or similar information multiple times for the different eligibility processes or for different portions of a single application. Workers enter data into the system primarily from information gathered in face-to-face meetings with the clients at more than 300 state eligibility offices or at 367 other eligibility determination sites, such as hospitals.

Legislative direction to modernize the automation system supporting eligibility determination began in 1995. This legislative direction was soon broadened to include improving business processes by integrating the several eligibility processes. The goals in modernizing the eligibility system are to expand the options available to clients for accessing services, to allow clients to access a wide array of services though a single process and contact point, and to make better use of taxpayer dollars.

The need for change is clear and compelling. The state's legacy eligibility system is badly out of date. For example, the IT systems that are vitally important to eligibility determination rely on a computer language, COBOL, which colleges no longer teach. Additionally, the system's one-size-fits-all business model relies on face-to-face meetings between eligibility staff and clients. This approach makes it especially difficult for working Texans to apply for benefits, since they often have to take time from work to apply for benefits in person.

In addition to the legacy system's technical limitations, it is a staff- and resource-intensive model that cannot respond to caseload growth without substantial increases in appropriations. In 2002, there was an average of 9,142 filled eligibility determination staff positions and slightly more than four million total Medicaid, Food Stamp, and TANF recipients, resulting in an average caseload of 442 recipients per filled position. To meet increasing needs for these programs, current staffing and funding levels would need to increase by 6,300 staff and $287 million per year to achieve caseloads at the 2002 level.

The new system will allow clients to apply for services through multiple channels. Clients may still apply in person, or they may avail themselves of new options, applying through call centers, over the Internet, by mail, or by fax. Providing these new options modernizes the business model for eligibility services similar to the way the use of call centers and on-line services have provided greater administrative efficiency and consumer convenience in many areas of modern life, such as applying for unemployment benefits and Social Security, renewing licenses, and applying for mortgages. Also similar to many other modernized application processes, applicants for HHS System program benefits will also be able to track the status of their applications though automated phone systems or over the Internet.

The new system will clearly expand the ways people can apply for services. It is important to note, however, that the new system does not change the scope or quality of the services a client receives or the standards that determine if someone is eligible to receive assistance.

Continuing to Improve Protective Services

Beginning with the reforms outlined in Senate Bill (S.B.) 6, 79th Legislature, Regular Session, the Department of Family and Protective Services (DFPS) made major programmatic improvements that strengthened all areas of protective and regulatory services for the unprotected and vulnerable individuals of Texas. These reform efforts occurred in all of the main DFPS programs: Child Protective Services (CPS), Adult Protective Services (APS), and Child Care Licensing (CCL). DFPS received appropriations and legislative support that allowed it to significantly improve investigations, staff training, case-related decision-making, accountability, and the provision of needed services. Staff increases allowed for more manageable caseloads. Technology allowed staff to spend more time in the field with clients and promoted more timely documentation of critical case actions. Structures were put in place to allow more inclusion of communities and families in the delivery of services. This legislative support for DFPS reform was continued in S.B. 758, 80th Legislature, Regular Session, 2007. This legislation built on the foundation laid in the earlier reform efforts and focused additional resources and attention on keeping families together, reducing the length of time children are in foster care, and improving the quality and accountability of the foster care system.

These reform efforts have not been without challenges. Organizational change occurred while services continued to be delivered; staff of DFPS programs had to adapt to new policies, procedures, equipment, and training while maintaining their existing caseloads. The growth of the agency and its client base created other challenges. Stronger investigations and risk assessment in APS and CPS resulted in more clients' being identified as needing services, and they revealed a widening gap between these needs and the facilities and services available to meet the needs. In CCL and Purchased Client Services, revised standards and increased resources dedicated to regulation of providers have led to actions being taken to improve providers' performance and safety issues. In all areas of the agency, the rapid expansion of the workforce created challenges in keeping pace with hiring and office space, and in equipping and training employees to perform their evolving job responsibilities. Staff turnover remains a significant challenge.

In spite of these challenges, the services to vulnerable adults and children have seen marked improvements, as evidenced by process and outcome measures. Casework and documentation are occurring in a more timely fashion, families and communities are increasingly included as decision-makers in case planning, and employees are held to reasonable and consistent performance standards statewide. As DFPS continues to improve and innovate, an important task will be to evaluate the results of specific policy and operational changes and the overall systemic and cultural change to the organization. Efforts at evaluation have begun and will allow DFPS to adjust its current path where needed, and to generalize the lessons learned into its ongoing improvement efforts.

Significant Need for and Impact of Substance Abuse

Substance abuse is a pervasive problem in our state and nation and has a significant impact on Texas communities and families. It contributes to many serious physical and mental health conditions and unintentional injuries, and it is associated with high rates of child maltreatment, suicide, divorce, unwanted pregnancy, domestic violence, disability, unemployment, poverty, and homelessness. Substance abuse problems put severe pressure on the health care delivery, social services, and criminal/juvenile justice systems. These problems require significant efforts to prevent or mitigate their statewide effects.

Substance abuse prevention and treatment services are available to adult and youth populations. These services are delivered through community organizations that contract with the state. The service continuum ranges from universal prevention to treatment, which is provided in inpatient, residential, and outpatient settings. Approximately 85 percent of Texas' funding for substance abuse services is provided by federal block grant funds. The challenge is that these funds are only able to serve a small portion of the estimated need.

Substance abuse is an illness that is progressive, chronic, and relapsing. Biological, medical, psychological, emotional, social, and environmental factors contribute to substance abuse and dependence behaviors. According to the 2006 Texas Behavioral Risk Factor Surveillance System (BRFSS), approximately 48.5 percent of Texas adults consumed alcohol in the past month, 14.7 percent reported past-month binge drinking, and 4.6 percent were heavy drinkers. According to the 2002-2006 National Drug Use and Health Survey approximately 6.7 percent of Texans age 18 or older reported being past-month users of any illicit drug (e.g. marijuana, cocaine, crack, hallucinogens, inhalants, and heroin).

Among the youth population, the 2006 Texas School Survey of Substance Use found that approximately 66 percent of secondary school students reported having ever consumed alcohol in their lifetime. The national Monitoring the Future Survey (Johnston et. al, 2006) reported that binge drinking among college students surveyed was higher compared to the same age non-college peers and high school seniors. Marijuana is the most commonly used illicit substance among Texas youth. Approximately 26 percent of Texas secondary school students reported having ever smoked marijuana in their lifetime. Texas has higher prevalence rates of powder and crack cocaine than other states. According to the 2006 Texas School Survey, 2.9 percent of secondary students in Texas reported using cocaine during the previous month. In a national comparison, Texas was classified among the states with the highest prevalence rate. A substance that continues as a problem in both rural and urban communities is methamphetamine.

For FY 2007, 61,005 persons were served in DSHS-funded substance abuse treatment programs. Of these persons, approximately 12.6 percent (7,660) were younger than age 18. Of the total persons served in the treatment programs, 42.1

percent were Anglo, 34.3 percent were Hispanic, 17.3 percent were African American, and 6.4 percent were of all other population groups combined.

Substance abuse has profound personal and societal consequences.

- According to the National Conference of State Legislators, "the costs of drug abuse to society are estimated as high as $358 billion dollars, and drug abuse accounts for over 550,000 deaths." In 2000, the total economic cost associated with alcohol and drug abuse in Texas was estimated at $25.9 billion.
- The statistics presented in the 2004 National Highway Traffic Safety Administration's State Alcohol Related Fatality Rates revealed that Texas was the state with the largest number of alcohol-related fatalities in the nation. Of the 42,836 motor vehicle fatalities in the United States, 3,699 occurred in Texas. Of these 3,699 motor vehicle fatalities, 46 percent (1,704) were alcohol-related, which is higher than the national average of 39 percent.
- In Texas, the Department of Family and Protective Services reports that of those children removed from their home, parental substance abuse was a contributing factor in more than 58.6 percent of the cases.
- In Texas, it is estimated that approximately 3,000 driving-while-intoxicated offenders and 15,000 low-level, non-violent drug offenders are newly incarcerated each year.
- Alcohol misuse has been linked to suicides, chronic liver diseases, and other illnesses. Chronic liver diseases such as cirrhosis are mainly caused by ingesting large quantities of alcohol over many years. The chronic liver disease death rate in Texas is increasing and is more prevalent among the older males. In 2003, 2,300 Texans died from chronic liver disease, and the state's death rate (10.5 per 100,000) is higher than the national rate of 9.5.

Contracting for the Provision of Services

Contracting for the provision of services is of vital importance to the HHS Enterprise. Services procured through contractual arrangements are essential to the direct provision of services to clients and to the myriad of services that support the administration and operation of the HHS System. Providers of contract services are most often in the private, for-profit sector, but substantial contractual relationships and dependencies also exist with providers or vendors operating as non-profit organizations and with local or regional governmental entities. Several procurement models are used to select contractors. Competitive procurement processes, some of which involve extremely complex and substantial procurements, are used to select the vendors of many services. Another procurement model is open enrollment, through which thousands of providers may receive funds for the provision of health or social services directly to clients, if they meet appropriate standards or criteria. The breadth and diversity of contracted services across the

Enterprise can be seen by noting a few of the major contracts or contract types at each agency.

HHSC's major contracts include those related to Medicaid and CHIP, including the financial agent contract, and family services such as those related to the family violence and the healthy marriage programs. Major contracts under DADS' purview include those with nursing facilities, community-based home and community support services agencies, and Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR). DFPS' major contracts include those for Services to At-Risk Youth, child-placing agency foster homes, emergency client services for APS clients, and residential treatment centers. DSHS' major contracts include contracts related to community-based behavioral health services, WIC card participation, Title XX family planning services, emergency medical services (EMS) upgrades for pre-hospital care, Title V family planning and maternal and child health services, and hospital preparedness to counter potential terrorism threats to civilian populations. DARS contracts with various vendors, to provide services and equipment such as wheelchairs, vehicle modification services, training, and assistive technology devices, to individuals with disabilities.

A one-size-fits-all contract management model is not appropriate to the mix and variety of contracts throughout the HHS Enterprise, and the Enterprise is committed to ensuring all contracts promote delivery of quality services to Texans, at a fair price, and with clear accountability. Agencies in the HHS Enterprise work to ensure that vendors have clear direction, are not administratively burdened with unnecessary or duplicative requirements, and are treated fairly.

In recognition of the criticality of strong procurement and contract management practices to the fiscal accountability and quality of its services, the HHS Enterprise has undertaken sustained efforts to strengthen procurement and contracting practices. Among the many facets of this comprehensive effort are:

- Creation of a contract oversight unit at each agency in the HHS Enterprise;
- Creation of an interagency Contract Council to promote best practices and improvements across the HHS Enterprise;
- Systematic efforts, often involving the Inspector General, to prevent or detect contractor fraud;
- Development of a contract tracking system for the HHS Enterprise;
- Publication of guidance on HHS Enterprise outsourcing;
- Training on procurement and contracting for HHS Enterprise employees; and
- Increased used of performance-based contracts.

Many of these efforts are discussed with more detail in other sections of this document.

Efforts to strengthen procurement and contracting practices across the HHS Enterprise are an ongoing priority. Improving internal systems and practices present

additional opportunities. Staff turnover requires ensuring that employees with new or expanded contract-related responsibilities receive appropriate training. Compensation levels must be adequate to retain employees who develop the specialized expertise needed to effectively procure and manage the unique, extremely complex, and substantial contracts supporting critical client services or agency support services. These challenges require constant attention and emphasis across the HHS Enterprise. Although the investments necessary to achieve and sustain exemplary contract management practices are not large in the context of Enterprise agency budgets, these investments help determine the effectiveness and efficiency with which state budget dollars are spent.

Statewide Demographic, Economic, and Health Trends

Key demographic and socioeconomic trends define the complex environment in which the HHS System operates. This discussion addresses key demographic and economic trends, including changes in population size, race/ethnic composition, and age distribution, which could impact the HHS System. The implications of these trends are discussed later in this Plan, in the Challenges and Opportunities section of this chapter and in the agency chapters.

In this Plan, the demographic terminology used is the same as the terminology used by the Texas State Data Center (SDC), with the exception that this Plan uses "African American" where the SDC uses "Black." Accordingly, the following terms have the following meanings:

- **Anglo—**White, non-Hispanic,
- **Hispanic—**Cultural identification, including any race;
- **African American—**Black, non-Hispanic, and
- **All other population groups combined—**All racial/ethnic groups not included in the categories above, with examples including Chinese, Vietnamese, Native American, Eskimo, and others.

Historical Population Growth Trends

The Texas population is growing faster than the national population, as has happened every decade since Texas became a state. From 1990 to 2007, the Texas population grew by 41 percent, from 17.0 million to 23.9 million.[1] During the

[1] Source: U.S. Census Bureau; Population Division.

same period, the United States (U.S.) population increased by 21 percent, from 249 million to 302 million.[2]

The Texas share of the national population increased from 7 percent in 1990 to 8 percent in 2007. In 1990, one in 15 people in the U.S. lived in Texas. By 2007, one in 13 people in the U.S. lived in Texas. With close to 24 million residents, Texas currently ranks second in total population behind California's 36.6 million.[3]

According to estimates published by the U.S. Census Bureau, the state's population grew, on average, by approximately 422,000 persons per year during the 2000-2007 period. Natural increase (the difference between the number of births and deaths) accounted for 54 percent of the growth during that period, while migration accounted for the remaining 46 percent. Of the migrants coming into the state, the Bureau estimates that 59 percent came from outside the U.S.

Future Population Growth Trends: Four Possible Scenarios

The SDC develops population projections based on four population growth models or scenarios. Although all the scenarios are based on the same assumptions regarding future fertility and mortality rates, each of them assumes different rates of net migration to project the population.

Comparing the different scenarios, the 0.0 migration scenario projects the least growth, projecting a total population of 23.3 million for 2013. This scenario assumes that natural increase will be the only factor driving future population growth. By contrast, the 1.0 migration scenario projects the most growth, projecting a total population of 27.9 million for 2013. This scenario assumes that future net migration rates will be the same as those experienced during the 1990-2000 period.

The other two scenarios are the 0.5 and the 2000-2004 migration scenarios. The 0.5 migration scenario is based on the assumption that future net migration rates will be half the size of those experienced during the 1990-2000 period. The 2000-2004 scenario assumes that future net migration rates will be the same as those estimated for the 2000-2004 period. Based on the 0.5 migration scenario, the state's population is projected to reach 25.4 million in 2013. Based on the 2000-2004 scenario the population is projected to reach 26.6 million in 2013.

[2] Source: U.S. Census Bureau, Population Division.
[3] Source: U.S. Census Bureau, Population Division.

Figure 3.1
Projected Texas Population Growth
Based on Texas State Data Center Population Projection Scenarios

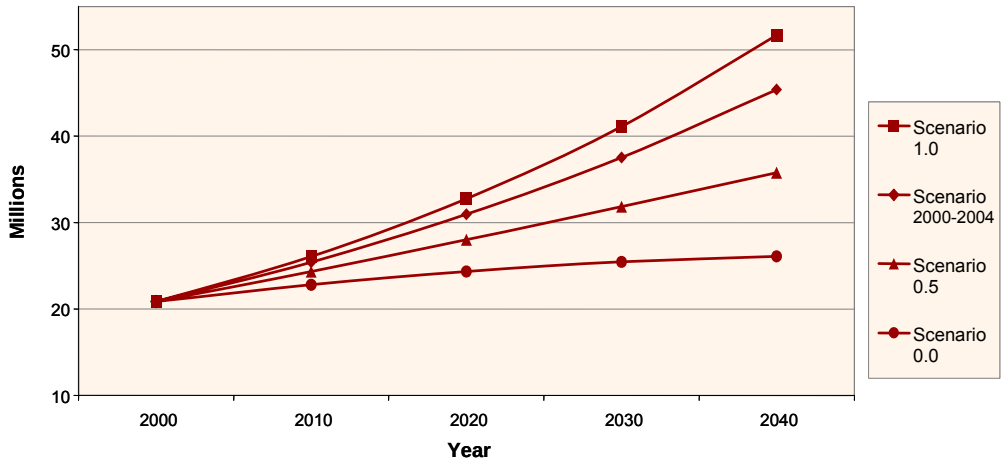


Figure 3.1: Texas State Data Center; HHSC Strategic Decision Support.

Figure 3.1 illustrates projected long-term population growth (2000-2040 period) trends according to the four scenarios. The 1.0 migration scenario projects the most growth, with the population exceeding 51.7 million by 2040. The 0.0 migration scenario projects the least growth, with the population reaching approximately 26.1 million by 2040.

The 0.5 migration scenario projects a population of approximately 35.8 million by 2040, while the 2000-2004 scenario projects a population of approximately 43.6 million by 2040.

Population Growth Scenario for Strategic Plan

In this plan, the discussion of projected population growth trends is based on data derived from the SDC's 2000-2004 migration scenario. This scenario is chosen for two main reasons: 1) it incorporates information on post-Census 2000 net migration trends, and 2) analysis done by HHSC research staff indicates it is the scenario that scores the smallest amount of statistical variance when compared to a set of independent population estimates for 2006 and 2007 recently developed by the SDC and the U.S. Census Bureau.

Projected Total Population Growth

Based on the SDC 2000-2004 migration scenario, during the 2009-13 period, the Texas population is projected to increase by 2 million people or 8 percent, from 24.6

million to 26.6 million. Both natural increase and positive net migration are expected to drive population growth during those years. Although it is likely that migration levels will vary from year to year, it is expected that migration will continue to contribute to the overall growth of the population.

Projected Racial/Ethnic Composition of the Population

The race/ethnic composition of the Texas population will change dramatically in the first half of the 21st century due to different growth rates among the various racial/ethnic populations. The SDC projects the following population distribution by race/ethnicity in 2009:

- Approximately 11.3 million Anglos;
- Approximately 9.5 million Hispanics;
- Approximately 2.7 million African Americans; and
- Approximately 1.1 million people of all other population groups combined.

As shown in Figure 3.2, Anglos are projected to comprise 46 percent of the population in 2009; Hispanics will represent the next largest group at approximately 39 percent. African Americans will comprise approximately 11 percent of the population, and other groups combined will comprise close to 4 percent.

Figure 3.2
Projected Percent of Texas Population by Race/Ethnicity, 2009

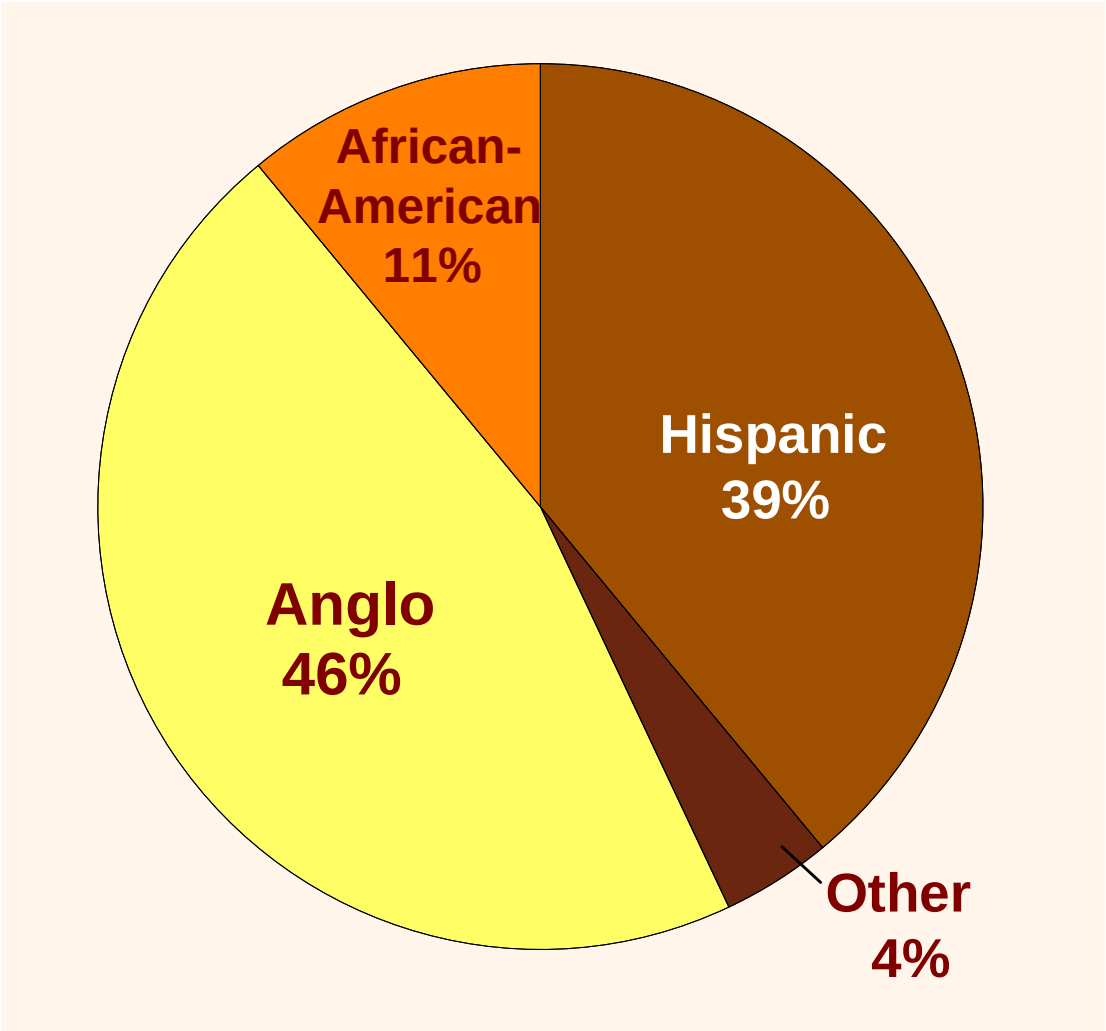


Figure 3.2: Texas State Data Center; HHSC Strategic Decision Support.

Based on the 2000-2004 migration scenario projections, the SDC anticipates the following growth between 2009 and 2013.

- The total population is projected to grow by approximately 8 percent, from 24.6 million to 26.6 million.
- The Anglo population is projected to grow by approximately 1 percent, from 11.3 million to 11.4 million.
- The African-American population is projected to grow by approximately 7 percent, from 2.7 million to 2.9 million.
- The Hispanic population is projected to grow by approximately 16 percent, from 9.5 million to 11 million.
- All other population groups combined are projected to grow by approximately 18 percent, from 1.1 million to 1.3 million.

Projected Long-Term Trends

Although this plan focuses on short-term trends (years 2009-13), it is useful to discuss potential long-term trends. Based on the SDC's 2000-2004 migration scenario, the state's population will grow by 19 million or 77 percent between 2009 and 2040, from 24.6 million to 45.6 million.

During that period, the Hispanic population is expected to grow the most in absolute terms in comparison to the other major racial/ethnic groups. However, the population including all other groups combined is projected to grow the most on a percentage basis. The size of the Anglo population is projected to decrease. The African-American population is projected to increase but at a modest rate in comparison with the rate of increase of the Hispanic population and the population of all other groups combined. As a result, Anglos and African Americans will comprise a smaller percent of the total population in 2040 than in 2009. Projections for the 2009 to 2040 period include the following.

- The Anglo population is projected to decrease by approximately 4 percent, from 11.3 million to 10.9 million.
- The African-American population is projected to increase by approximately 30 percent from 2.7 million to 3.5 million.
- The Hispanic population is projected to increase by approximately 166 percent from 9.5 million to 25.3 million.
- All other population groups combined are projected to increase by 245 percent from 1.1 million to 3.8 million.

Figure 3.3 illustrates these comparative growth rates.

Figure 3.3
Projected Texas Population Growth by Race/Ethnicity, 2009-40 (Millions)

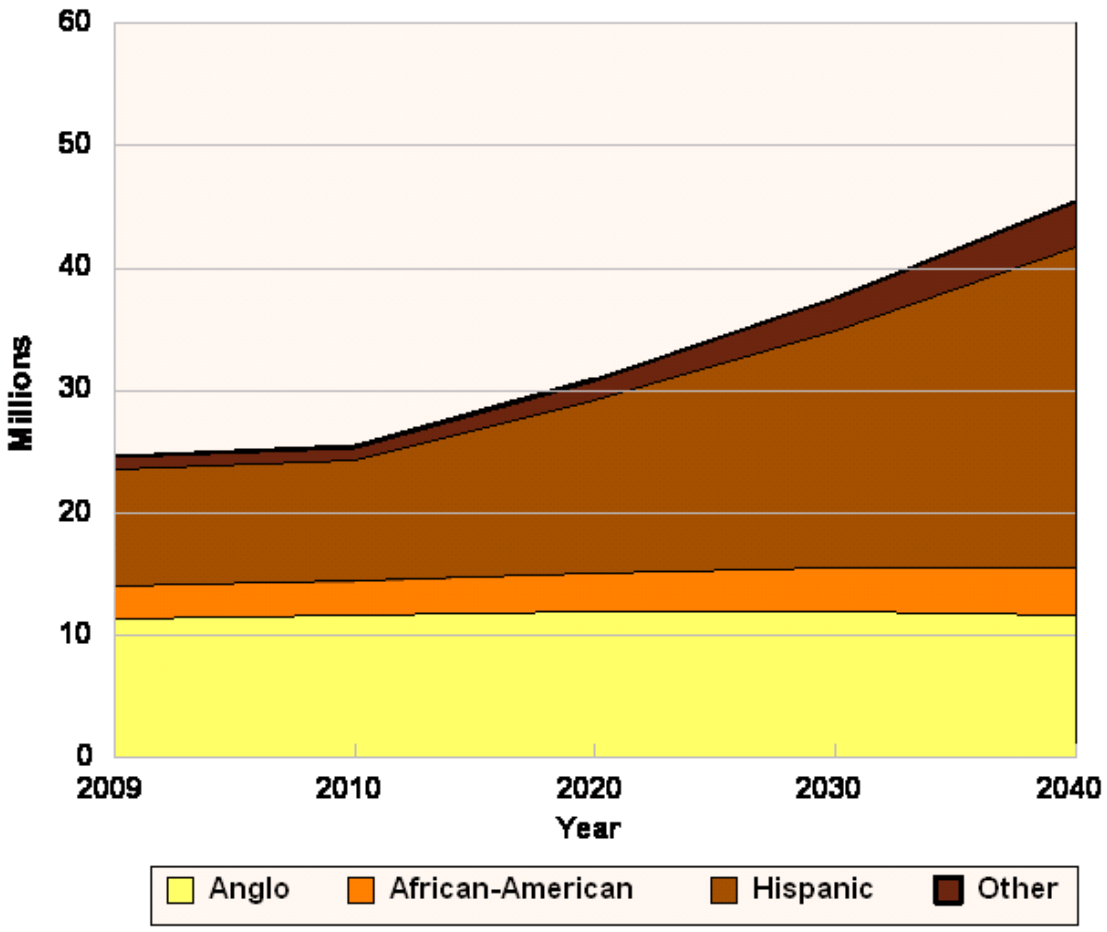


Figure 3.3: Texas State Data Center; HHSC Strategic Decision Support.

The Anglo share of the population is projected to decrease, from 46 percent to 25 percent, as shown in Figure 3.4. The African-American share is projected to decrease from 12 percent to 8 percent. The Hispanic share is projected to increase, from 38 percent to 58 percent. The combined percent share for all other population groups combined is projected to increase from 4 percent in 2009 to 9 percent in 2040.

Figure 3.4
Projected Percent of Texas Population by Race/Ethnicity, 2009-40

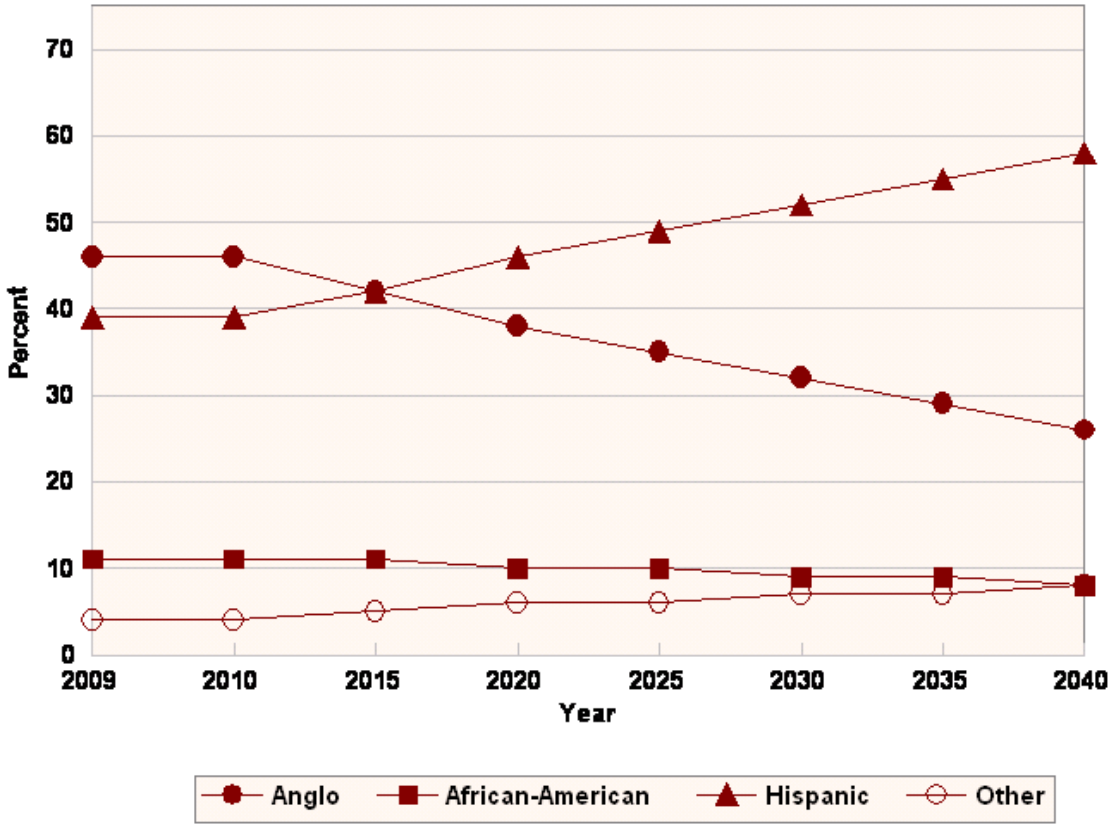


Figure 3.4: Texas State Data Center; HHSC Strategic Decision Support.

This substantial population growth could lead to additional demand for health and human services. Moreover, the growth of the non-Anglo population, which historically has experienced higher incidence of poverty and lack of insurance, could further contribute to the additional demand for public services. The implications of these dynamics are discussed in more detail later in this Chapter and in Chapter IX (DSHS).

Projected Aging of the Population

Trends projected by the SDC point to a substantial aging of the population. The population age 65 or older is projected to increase from 2.5 million in 2009 to 7.1 million in 2040, as shown in Figure 3.5. The percentage of the total population that is 65 years of age or older is projected to increase from 10 percent in 2009 to 16 percent by 2040.

Similarly, the percentage of the population 85 years of age or older is also projected to increase, from 1.2 percent in 2009 to 2.1 percent by 2040. Figure 3.5 illustrates the growth trends for the populations age 65 through 84 and those age 85 or older.

Figure 3.5
Projected Texas Population Growth for Selected Age Groups, 2009-40
(Millions)

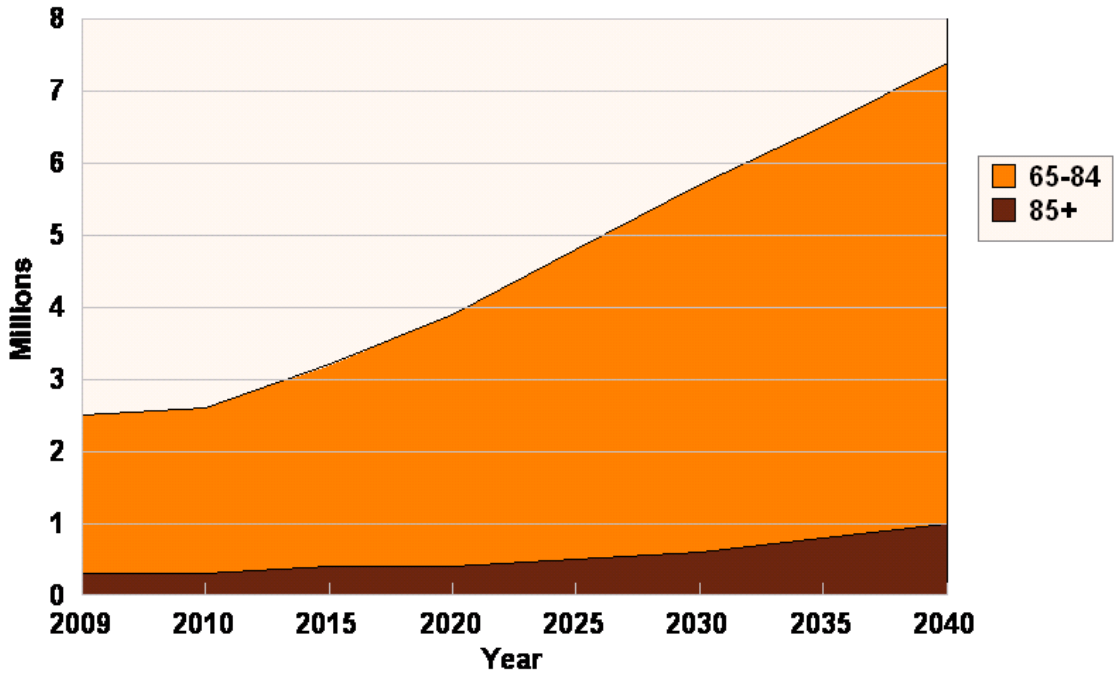


Figure 3.5: Texas State Data Center; HHSC Strategic Decision Support.

The median age for the population as a whole is projected to increase, from 33.2 years in 2000 to 37.8 years in 2040.[4]

The median age is projected to increase for all major race/ethnic groups. From 2000 to 2040, the anticipated increases in median age by race/ethnicity are as follows:

- For Anglos, an increase from 40.1 years to 44.6 years,
- For African Americans, an increase from 30.6 years to 39.2 years,
- For Hispanics, an increase from 27.9 years to 34.2 years, and
- For all other race/ethnicity groups combined, an increase from 33.4 years to 48.3 years.

Among the population age 65 or older, Anglos are projected to have the lowest rate of growth between 2009 and 2040. Although the number of persons 65 or older is projected to increase for all race/ethnic groups, the increase will be more dramatic in

[4] Source: Texas State Data Center.

the non-Anglo groups. Between 2009 and 2040, the following growth is projected in the population of persons age 65 or older:

- For Anglos, 64 percent,
- For African-Americans, 200 percent,
- For Hispanics, 420 percent, and
- For all other race/ethnicity groups combined, 1000 percent.

Figure 3.6 depicts the projected percent share of the 65 and older population in the years 2009 and 2040 according to race/ethnic group. The Anglo share, projected at 68 percent for 2009, is projected to be approximately 41 percent for 2040. The Hispanic share is projected to increase from 20 percent to 37 percent. The African-American share is projected to remain the same at 8 percent. The share of all other population groups combined is projected to increase from 3 percent to 15 percent.

Figure 3.6
Projected Percent of Texas Population 65 Years of Age or Older by Race/Ethnicity

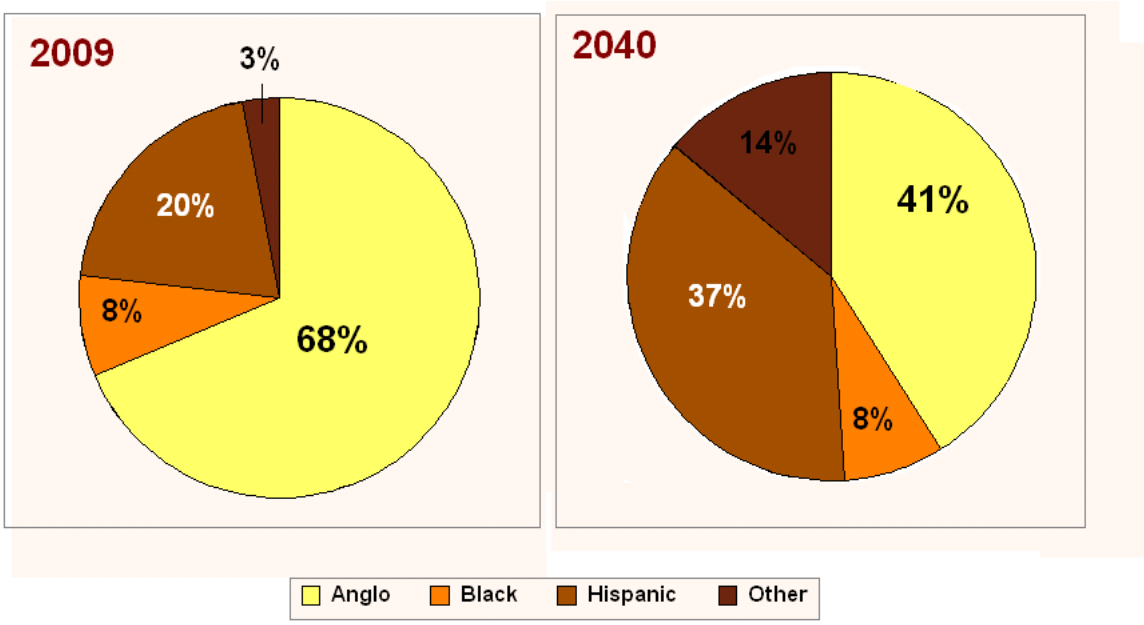


Figure 3.6: Texas State Data Center; HHSC Strategic Decision Support.

Prevalence of Disability by Age

Since the older population is projected to grow at a higher rate, it is likely that the percentage of the population as a whole who have a disability will increase. According to the 2006 American Community Survey (ACS), there were

approximately 3.1 million Texans age 5 or older with a disability. The ACS is a household survey, and the disability data are based on respondents' answers to questions about whether they, or any other person in the same household, have physical difficulties or any other difficulties involving activities such as dressing, going out, hearing/seeing, working, and remembering. These difficulties arise from a variety of sensory, physical, mental, or emotional disabilities.

According to the 2006 ACS, 15 percent of Texans had one or more disabilities or limitations. Among younger adults ages 18-34, 7 percent reported a disability. Among adults ages 65-74, 36 percent reported a disability. Among persons age 75 and older, 61 percent reported a disability. Figure 3.7 illustrates these percentages.

People with disabilities are more likely to need services such as protective and preventive services, acute health care, institutional and community-based long-term care, transportation, legal and advocacy services, assistance with home repair and home modifications, and assistance with navigating an increasingly complex system of social services.

Figure 3.7
Percent of Texas Population with a Disability by Selected Age Groups, 2006

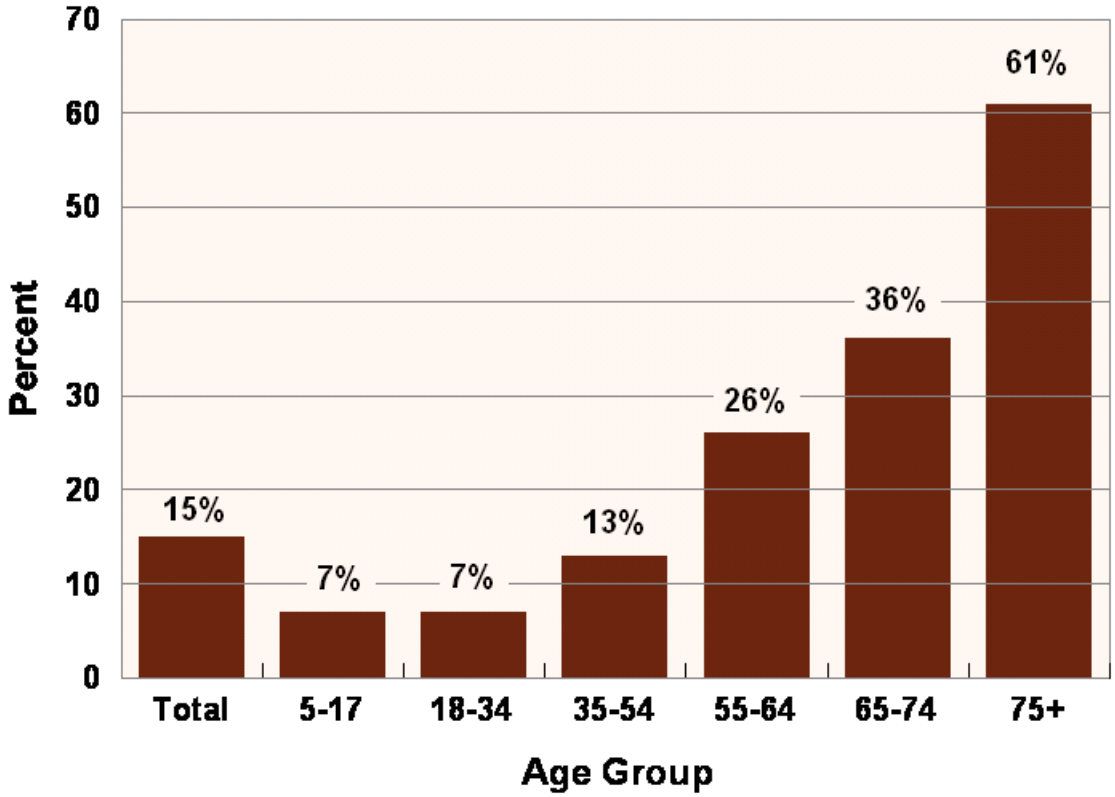


Figure 3.7: U.S. Census Bureau, American Community Survey, 2006; HHSC Strategic Decision Support.

Rural Population Concerns

Over the next 40 years, the trend toward urbanization in Texas is expected to continue. The U.S. Office of Management and Budget (OMB), based on U.S. Census data, classifies counties as metropolitan or non-metropolitan. 'Central' counties, those with a high population density urban core, and surrounding counties, that have a high degree of economic integration with the central county, are classified as metropolitan. Counties that do not posses those characteristics are classified as non-metropolitan. The more rural and isolated counties tend to fall under the non-metropolitan classification.

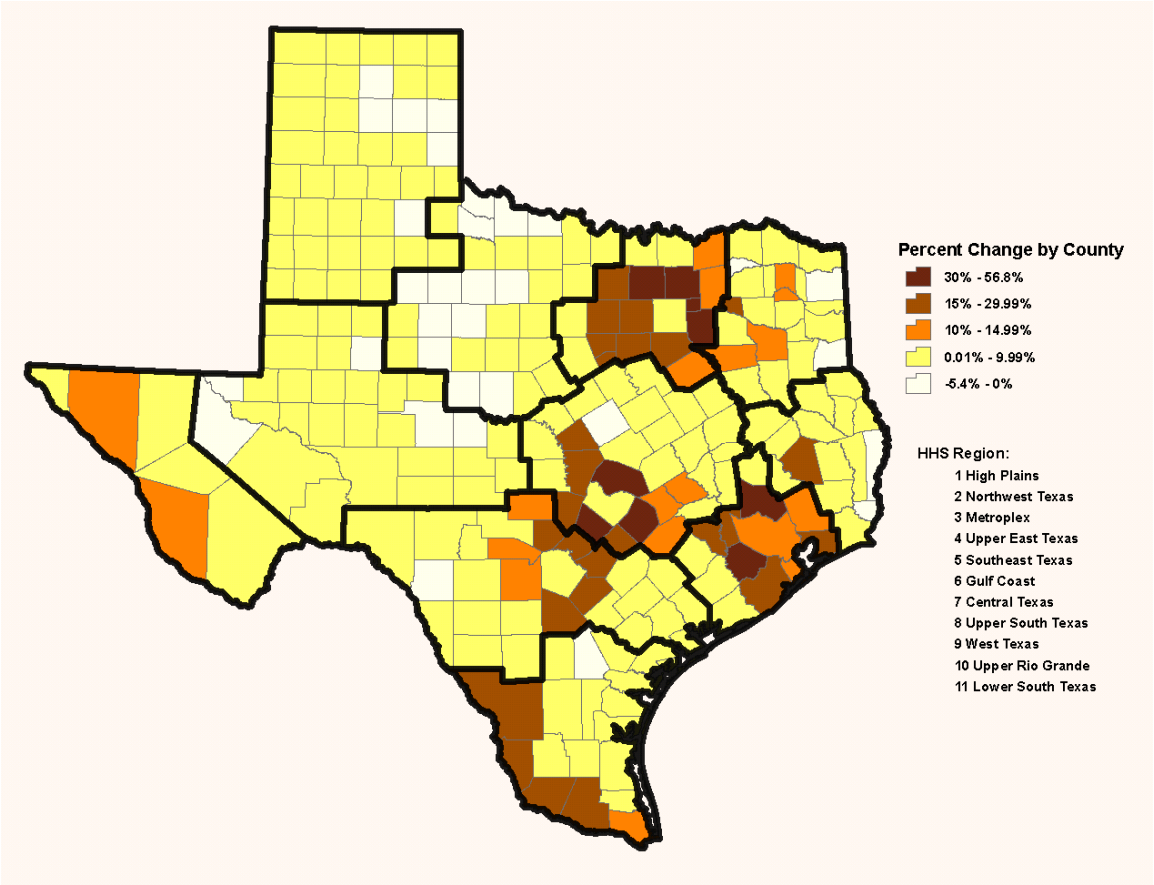
Currently, 177 Texas counties are classified as non-metropolitan by the OMB. It is projected that by 2009 approximately 3.2 million residents, or 12.8 percent of the Texas population, will reside in these counties. The population residing in the more rural, non-metropolitan counties is projected to increase at a lower rate compared to the population in the more urban metropolitan counties. According to the SDC, between 2009 and 2013 the number of Texans residing in non-metropolitan counties is projected to increase by approximately 98,000, while the number residing in metropolitan counties is projected to increase by 1.8 million.

The more rural and isolated areas present particular challenges for the delivery of health and human services. Below is a list of some of those challenges:

- Limited access to affordable health care;
- Limited number of trained health professionals;
- Increased need for geriatric services;
- Prolonged response times for EMS;
- Increased substance abuse (alcohol, prescriptions, and illegal drugs);
- Limited job opportunities and other incentives for youth to stay in the community
- Limited transportation options;
- Limited economic development; and
- Limited fiscal resources.

While the overall Texas population is projected to grow by 8.3 percent between 2009 and 2013, growth rates will continue to vary across the different regions of the state, as shown in Figure 3.8. Most growth is projected to take place in and around the larger metropolitan counties. The majority of the counties that are projected to experience growth of less than five percent, or no positive growth at all, are non-metropolitan. These trends could further exacerbate the challenges faced by the rural health and human service delivery system.

Figure 3.8
Texas Population Change by County, 2007-14



Economic Indicators

The health of the Texas and U.S. economies is a key concern for the HHS Enterprise. Economic downturns traditionally lead to both an increased demand for social services and a simultaneous decrease in the financial resources available to address the increased needs.

The Texas gross state product, the broadest measure pertaining to the size of the Texas economy, is forecast by the Texas Comptroller of Public Accounts (CPA) to reach $944 billion (in 2000 dollars) in FY 2009, and $1,070 billion in FY 2013. These projected amounts represent an approximate 3 percent increase per year, on average.

According to the CPA Fall 2007 Economic Forecast, between 2009 and 2013, per-capital personal income levels in Texas will increase at an average rate of 2.2 percent per year, after adjusting for the projected rate of general price inflation. Per

capita personal income is projected to increase from close to $40,000 in 2009 to $43,500 in 2013, after adjusting for inflation.

Figure 3.9
U.S. and Texas per Capita Income, 2009-13

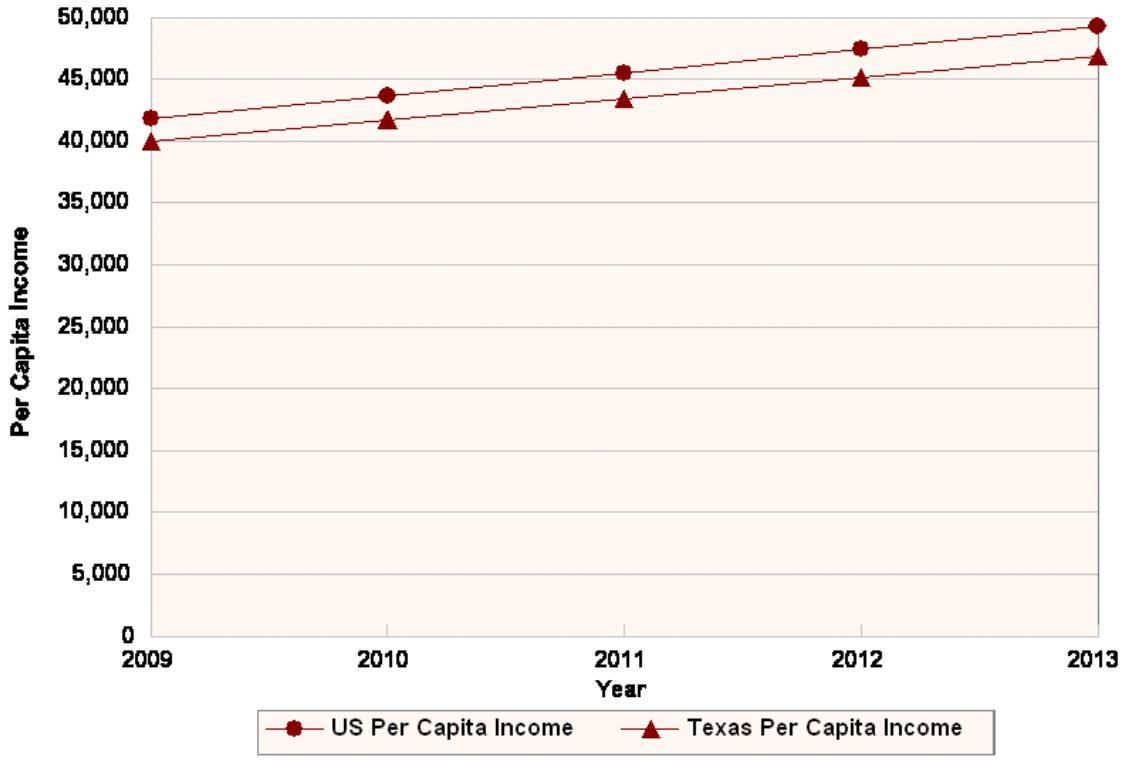


Figure 3.9: Texas Comptroller of Public Accounts; Global Insight.

The Texas economy enjoyed strong non-farm job gains in 2007. According to the latest employment estimates from the Texas Workforce Commission (TWC), the state gained 220,000 nonagricultural jobs in 2007 for an annual growth rate of 2.1 percent. Texas employment growth exceeded the national employment growth rate for 2007.

Poverty

The population living in poverty often relies on key services provided by the HHS System; consequently, it is useful to analyze poverty population growth trends to understand potential impacts on the HHS System.

The U.S. Department of Health and Human Services (U.S. DHHS) defined the poverty level for 2008 according to household/family size as follows:

- $21,200 or less for a family of four;
- $17,600 or less for a family of three;
- $14,000 or less for a family of two; and
- $10,400 or less for individuals.

It is projected that in 2009 approximately 4.1 million Texans, 16.8 percent of the population, will live in families with annual incomes falling below the federal poverty level (FPL). For 2013, it is projected that 4.6 million Texans, or 17.3 percent of the population, will live in families with annual incomes below the FPL.[5] For children younger than age 18, the projected poverty rates are 22.1 percent for 2009 and 22.6 percent for 2013.

Projected poverty rates for 2009 vary by race and ethnicity and are shown in Table 3.1. Even if poverty rates were to stay constant between 2009 and 2013, the number of people below the FPL would grow, because the state population will grow during the same time period.

Table 3.1
Projected Poverty Rates for the Texas Population by Race/Ethnicity, 2009

Year	Anglo	African American	Hispanic	Other Groups
2009	8.2%	24.9%	25.2%	13.3%

Table 3.1: U.S. Census Bureau, 2007 March Current Population Survey; Texas State Data Center; HHSC Strategic Decision Support.

The projected rate of poverty for children also varies by race and ethnicity, with rates being higher for non-Anglo children. In both 2009 and 2013, a projected 7.5 percent of Anglo children will live in families with annual incomes below the FPL, compared with 33.0 percent of African-American children, 31.1 percent of Hispanic children, and 19.7 percent of children in all other population groups combined.

[5] Source: U.S. Census Bureau, March 2007 Current Population Survey (CPS), 2007, for Texas; Texas State Data Center Population Migration Growth Scenario 2002-2004, v. 10/06; HHSC Strategic Decision Support.

Unemployment

Unemployment also influences the demand for social services. In Texas, unemployment has continued to decrease and to stabilize. In January 2008, the Texas unemployment rate was 4.3 percent, down from 6.4 percent in January 2004.[6] The expected growth in Texas non-farm employment and other economic indicators suggests that the unemployment rate will remain relatively stable during the planning period, averaging approximately 4.9 percent on an annual basis during the 2009-13 planning period, as illustrated by Figure 3.10.

Figure 3.10
U.S. and Texas Unemployment Rate Projections, 2009-13

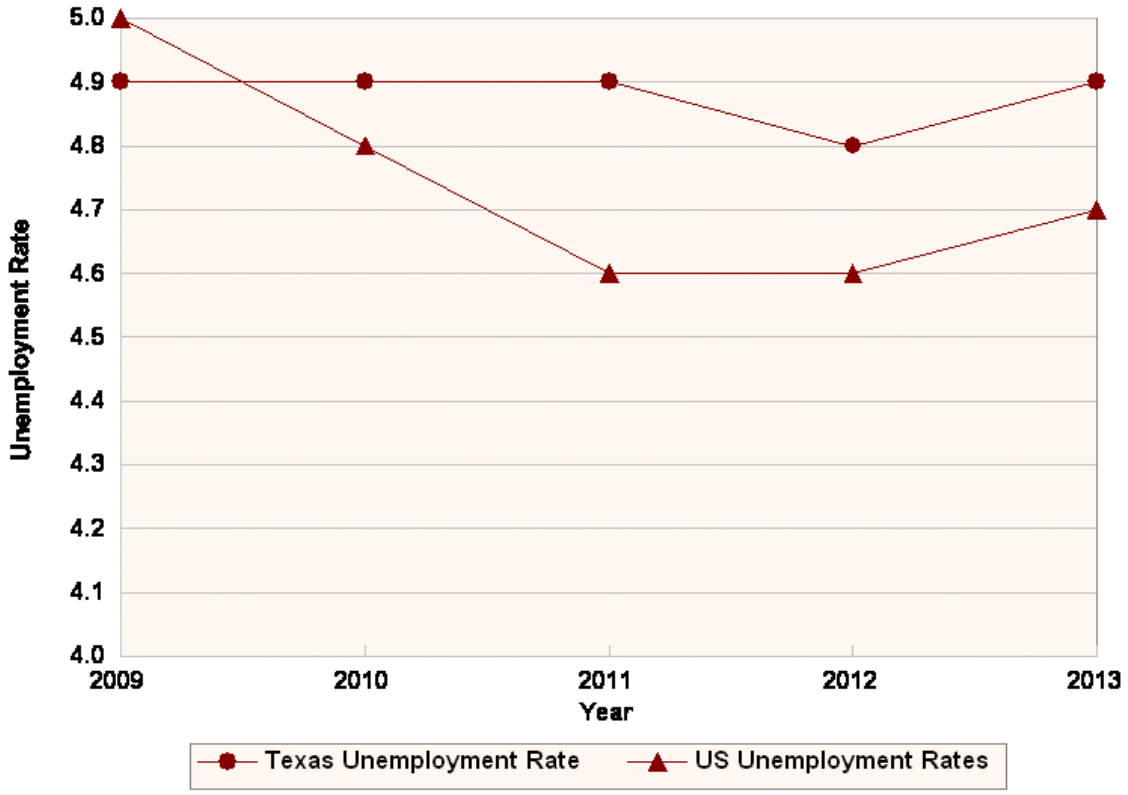


Figure 3.10: Texas Workforce Commission; HHSC Strategic Decision Support.

[6] Source: Office of the Comptroller.

Health Insurance Status [7]

The regular sources for health insurance are: private group insurance, individual insurance, and public insurance. Public insurance includes programs such as Medicaid, the CHIP, military insurance, and Medicare. Most people obtain their coverage from one source; however, some people obtain coverage from more than one source. For example, many people 65 years of age and older are covered by Medicare and by private insurance. Insurance status is of vital importance to the HHS System because low-income individuals and families who are uninsured are more likely to turn to state or local government to meet their health care needs.

In the national population in recent years the percentage of privately insured people younger than age 65 has been declining. This trend exists in Texas, where the percentage of these people declined from 65 percent to 59 percent from 2000 to 2006. One reason often cited to explain this decline is the significant rise in health care costs.

Compared to other states, Texas has the second lowest percentage for private health insurance coverage among persons younger than age 65. By contrast, in 2006, Hawaii had the highest percentage of people with private health insurance coverage (78.3 percent) in the population younger than age 65.

Statewide, for the population younger than age 65, the percent with private coverage varies according to race/ethnicity as follows:

- 76.9 percent coverage for Anglos;
- 52.6 percent coverage for African Americans; and
- 38.5 percent coverage for Hispanics.

For people younger than age 65 with incomes below 200 percent of the FPL, the percent with private coverage varies according to race/ethnicity as follows:

- 46.7 percent coverage for Anglos;
- 25.7 percent coverage for African Americans; and
- 18.9 percent coverage for Hispanics.

For people younger than age 65 whose income exceeded 200 percent of the FPL, disparities also exist in the percent with private insurance coverage.

- 85.0 percent coverage for Anglos;
- 74.8 percent coverage for African Americans; and
- 63.1 percent coverage for Hispanics.

[7] Data cited in this section were obtained from the U.S. Census Bureau's March 2007 Current Population Survey (CPS).

The percent of children younger than age 18 with private health insurance also varies according to race/ethnicity. In 2006, approximately 76.3 percent of Anglo children were covered by private health insurance; by contrast, only 44.3 percent of African-American and 32.2 percent of Hispanic children were covered by private health insurance.

Regarding the Texas uninsured population, estimates for 2006 derived from the U.S. Census Bureau's March 2007 Current Population Survey indicate the following information.

- **Children Younger than Age 18**—An estimated 21.2 percent or 1.4 million Texas children were uninsured. Nationally, an estimated 11.7 percent were uninsured.
- **Population Younger than Age 65**—An estimated 27.2 percent or 5.5 million Texans younger than age 65 were uninsured. Nationally, an estimated 17.8 percent were uninsured.
- **Total Population**—An estimated 24.5 percent or 5.7 million Texans were uninsured. Nationally, an estimated 15 percent were uninsured.

The estimated percent of people without health insurance in 2006 by major race/ethnic group is higher for Texas compared to the nation as a whole.

- **Anglos—**12.8 percent in Texas *versus* 10.8 percent nationally;
- **African Americans—**25.8 percent in Texas *versus* 20.1 percent nationally;
- **Hispanics—**39.8 percent in Texas *versus* 34.1 percent nationally; and
- **All other population groups combined—**24.3 percent in Texas *versus* 16.7 percent nationally.

The State of Texas plays an especially important role in providing health insurance coverage for low-income children. In July 2007, 2.4 million low-income children younger than age 19 were enrolled in Medicaid and CHIP. These children represent approximately one-third of all the children in the state.

Health Risk Factors

Infant Mortality and Low Birth Weight

The infant mortality rate (IMR) historically serves as an important indicator of the overall health of the community and the accessibility of medical care for pregnant women and infants. The IMR is the number of infant deaths (ages 0 to 12 months) per 1,000 live births per year. The overall IMR in Texas in 2004 was 6.3 per 1,000 live births, with African-American infants having an IMR of 12.8, Anglos and Hispanics each at 5.6, and all other population groups combined having an IMR of 3.6.

Low birth weight, defined as less than 2,500 grams, is correlated to increased risk for adverse health outcomes, such as cerebral palsy, mental retardation, vision impairments, hearing impairments, other developmental disabilities, and even death. In 2004, eight percent of Texas newborns had a low birth weight. The percentage of low birth weight African-American infants (13.9 percent) was almost twice that of both Anglo (7.4 percent) and Hispanic infants (7.2 percent). Teen mothers are most likely to have low birth weight babies, followed by mothers older than 40 years.

Chronic Disease

Chronic diseases are the major cause of illness, disability, and death in Texas. They are generally characterized by multiple risk factors, a long latency period, a prolonged course of illness, non-contagious origin, functional impairment or disability, and low curability. These diseases claim the lives of more than 101,000 Texans every year and are responsible for seven of every ten deaths. As shown in Figure 3.11, four of the five leading causes of death in 2004 were chronic diseases, including heart disease, cancer, stroke, and chronic lower respiratory diseases.

Figure 3.11
Leading Causes of Texas Deaths, 2004

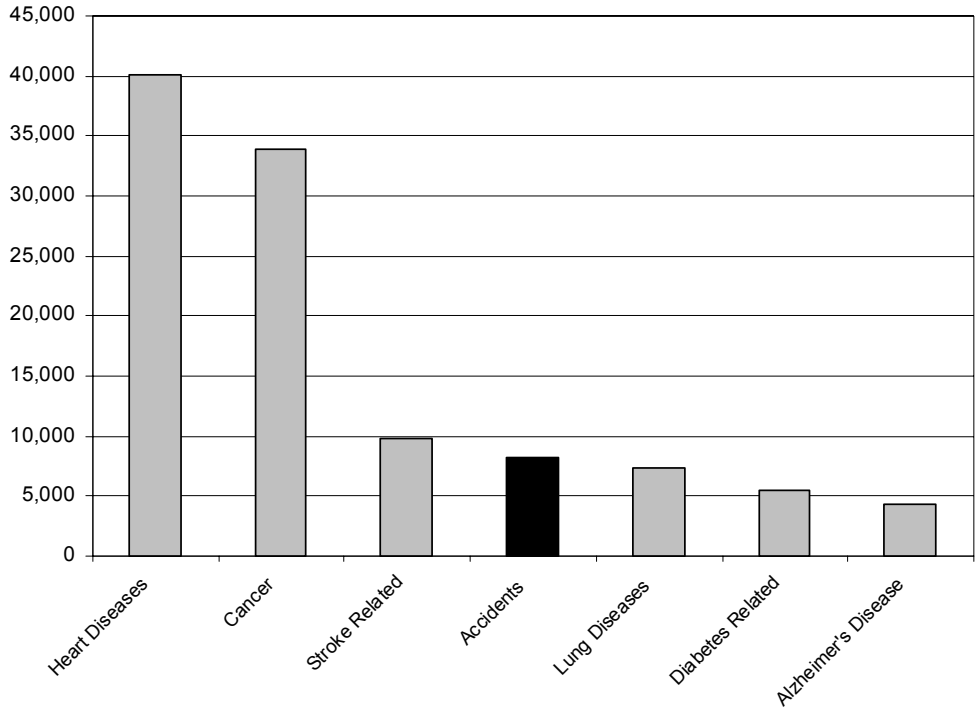


Figure 3.11: Department of State Health Services. Gray-shaded bars represent chronic disease deaths, while the bar representing accidents is marked with black shading.

Table 3.2
Leading Causes of Texas Deaths, 2004

Ranking	Disease	Number	Percentage
1	Heart Diseases	40,041	26.3%
2	Cancer	33,836	22.2%
3	Stroke-Related	9,831	6.5%
4	Accidents	8,270	5.4%
5	Lung Diseases	7,387	4.8%
6	Diabetes-Related	5,426	3.6%
7	Alzheimer's Disease	4,331	2.8%
8	Influenza and Pneumonia	3,198	2.1%
9	Kidney Disease	2,557	1.7%
10	Blood Infections	2,420	1.6%
All Other Causes		35,027	23.0%
Total Deaths in 2004		152,374	100.0%

Table 3.2: Department of State Health Services.

Infectious Disease

Bacteria, viruses, or other microorganisms cause infectious diseases. Many of the infections plaguing Texans have common modes of transmission that relate to behaviors.

At the end of 2006, a total of 60,571 Texans were living with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). In 2006, there were 4,621 new diagnoses of HIV/AIDS. The rate of persons living with HIV/AIDS among African Americans in 2006 was more than four times higher than the rate in Anglos, and approximately five times higher than the rate in Hispanics.

TB is a statewide problem that is especially severe in border counties and large cities. In 2006, there were 1,585 cases of TB reported, making the incidence rate in Texas 6.8 per 100,000. This rate is 48 percent higher than the national rate of 4.6 per 100,000.

Figure 3.12
Tuberculosis Cases in Texas, 2006

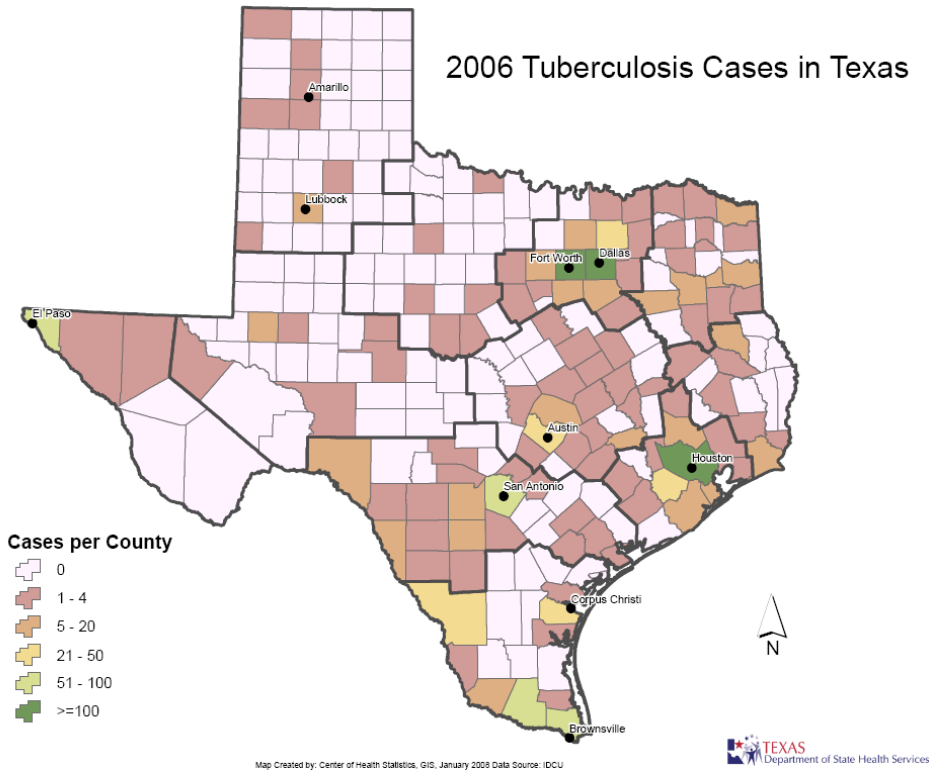


Figure 3.12: Department of State Health Services, 2008.

Mental Health

Mental illnesses are a leading cause of disability in the U.S., Canada, and Western Europe. According to estimates by the federal government, as many as 4,147,132 Texans have a mental illness. Among those, an estimated 937,031 adults in Texas will meet the DSHS mental health priority population definition in FY 2007.[8] An estimated 451,163 in the priority population are considered to be seriously and persistently mentally ill. That same year the priority population of children and adolescents in mental health community-based programs was estimated to be approximately 159,402.[9]

[8] The Adult Mental Health priority population consists of adults who have severe and persistent mental illnesses such as schizophrenia, bipolar disorder, major depression, or other severely disabling mental disorders and who require crisis resolution or ongoing and long-term support and treatment, and any individual who is believed to be in a crisis and requires stabilization.
[9] The Children's Mental Health Priority Population consists of children ages 3-17 with a diagnosis of mental illness or serious emotional, behavioral or mental disorders, and who:
Have a serious functional impairment; or

Prevalence of mental illness varies by characteristics such as gender, ethnicity, and age. For example, nationwide nearly twice as many women as men suffer from a depressive disorder each year. However, according to the Centers for Disease Control and Prevention, four times as many men as women commit suicide, with Anglo males committing 73 percent of all suicides in 2002. In 2004 in Texas, Anglo males committed suicide at two and half times the rate of African-American males and three times that of Hispanic males. The highest suicide rate usually occurs among persons ages 65 and older.

Access to mental health care may also differ by demographic variables. At a time when racial and ethnic minorities comprise a substantial and rapidly growing segment of the U.S. population, the health care system has not kept pace with the diverse needs. As a result, minority populations are often underserved or served inappropriately. The Office of the U.S. Surgeon General reports that racial and ethnic minorities are less likely than Anglos to receive mental health services, less likely to have health insurance, and more likely to receive poorer quality of care for a mental illness. Minorities are also over-represented among those who have mental disorders and are homeless, incarcerated, or institutionalized. Disparities in care also affect residents of underserved or rural areas, a group that comprises 25 percent of the U.S. population.

Behavioral Risk Factors Affecting Health

In Texas, each of the seven leading causes of death can be linked to one or more significant behavioral risk factors. Three risk-related behaviors are the major contributors to cardiovascular disease and cancer: tobacco use, poor nutrition, and physical inactivity. Related data and the consequences of these behaviors are described below, using information from the BRFSS.

Tobacco use is a leading cause of preventable death and disease in Texas. Almost 60,000 youth in Texas become daily smokers each year, and 20,000 of them will ultimately die from smoking. In Texas:

- More than one in five Texas adults currently smoke.
- Tobacco use is the single largest cause of preventable death and disease.
- Both nationally and in Texas, Anglo adults are more likely to smoke than African Americans and Hispanics; males are more likely to smoke than females; and young adults are more likely to smoke than older adults.
- In 2003, ten percent of middle school students and 25 percent of high school students reported having smoked cigarettes on at least one of the 30 days preceding the survey.

Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or Are enrolled in a school system's special education program because of a serious emotional disturbance.

- Anglo and Hispanic high school students were more likely to smoke than African Americans, and among middle school students, Hispanics were much more likely to smoke than Anglos and African Americans.
- Tobacco use costs Texas more than $10 billion annually, or $499 for every person in the state, including medical care costs and lost productivity.

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

- In 2006, an estimated 10.1 million or 62 percent of Texas adults were overweight or obese.
- If the current trends continue, 20 million or 75 percent of Texas adults might be overweight or obese by the year 2040, and the cost to Texas could quadruple from $10.5 billion today to as much as $39 billion.
- Compared to the other U.S. states, Texas has had a high average rate of obesity in the adult population:
  - 25.3 percent between 2002 and 2004 (sixth highest);
  - 25.8 percent between 2003 and 2005 (tenth highest); and
  - 26.3 percent between 2004 and 2006 (twelfth highest).

Unfortunately, Texas dropped in ranking, because the prevalence of obesity increased in other states, not because the rate of obesity had improved in Texas.

Of particular concern is the increasing incidence of overweight youth, whose lifestyle patterns, once established in formative years, are likely to continue into adulthood.

- The prevalence of childhood overweight was greater in Texas in 2004-05 than the U.S. rates reported for the *National Health and Nutrition Examination Survey, 2003-2004.*
- The overall prevalence of overweight and at-risk for overweight in Texas school children in 2004-05 was 42 percent for fourth-graders, 39 percent for eighth-graders, and 36 percent for eleventh-graders.
- In 2004-05, the percentage of overweight students in Texas was much higher among minorities, with the highest prevalence of overweight in Hispanic boys in 4th grade and 11th grade.
- In 2005, 29 percent of Texas high school students were overweight or at risk of becoming overweight.
- In the past decade, the number of overweight children and teens has doubled.

Regular physical activity, even in moderate amounts, has been shown to produce significant health benefits. Despite this fact, the BRFSS showed that in 2006, many adults in Texas reported little or no exercise.

- In Texas, 28.4 percent of adults reported no leisure-time physical activity in the past month, compared to 24.2 percent of adults nationwide.
- Of Hispanics in Texas, 38.1 percent reported no physical activity, compared to 34 percent of African Americans and 23.7 percent of Anglos.
- According to the BRFSS in 2004, 28 percent of Texas adults reported spending four or more hours during a typical day sitting and watching television, watching videos, or using a computer outside of work.
- According to the Youth Risk Behavior Surveillance System in 2005, 41 percent of Texas adolescents in grades 9-12 watched television for three or more hours per day on an average school day.

Alcohol abuse is another underlying factor in a wide range of health problems. The following statistics characterize alcohol abuse or use in Texas.

- In 2000, the economic impact of alcohol abuse was $16.4 billion, a total that includes health care expenditures, lost productivity, motor vehicle accidents, crime, and other costs.
- Of the 3,475 motor vehicle fatalities in Texas in 2006, 1,677 (48 percent) were alcohol-related.
- Alcohol continues to be the most widely used controlled substance among secondary school students in Texas. In 2006, 66 percent of these students reported they had used alcohol, while 32 percent reported past-month alcohol use.
- Alcohol was the easiest controlled substance for secondary students to obtain, with parties and friends being the major sources.

Illicit drug use is costly to the individual, the family, and society.

- The economic impact of illegal drug use in 2000 in Texas was $9.5 billion.
- Approximately 48 percent of secondary school students reported that they were not drug-free from all substances, including alcohol, during the 2006 school year.
- In 2002, 68 percent of jail inmates reported symptoms that met substance dependence or abuse criteria in the year before their admission to jail.
- In 2007, 28 percent of all adults served in the Texas public mental health system were diagnosed with a co-occurring substance abuse disorder.

HHS System Strengths

Optimization and Transformation Successes to Date

HHS Enterprise agencies continue to actively pursue the vision of House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003. One area of transformation that is increasingly successful is the continuing commitment of agency management to meet the goals of consolidation—improve services, achieve efficiencies, and enhance accountability. Numerous optimization projects have been completed, are being completed, or are planned by agencies. The sections that follow highlight some of the projects and beneficial outcomes that have been achieved as well as projects and benefits still to be completed or undertaken.

HHSC

HHSC optimization projects can be found across the agency. One such initiative is focused on communication. In response to feedback from stakeholders, HHSC is undertaking an initiative to make plain language a defining feature of all program communications including those for eligibility services, family services, and Medicaid/CHIP.

Feedback from stakeholders, some of whom were helping people fill out applications and other forms, indicated that the information being requested often contained too much program jargon, requirements weren't always clearly explained, and instructions were sometimes ambiguous. HHSC communications staff is training program staff to better understand client perceptions of material. Staff members already are rewriting existing service applications, letters, brochure copy and more. Future communications, not only printed materials but also Web content and video scripts, will be held to the same standards of clarity and user-friendliness. This plain writing campaign is part of a broader communications effort that also focuses on readable document design, audience-appropriate Spanish translations, and an overall less-is-more philosophy.

HHSC's continuing efforts to improve administrative and support services for the HHS Enterprise are the focus of several projects. Regional Administrative Services that support all Enterprise agencies are now in place and operating within a framework of service level agreements between HHSC and the other Enterprise agencies. Examples of further improvement efforts include testing of multi-agency scanning software that will streamline the inventory process for all Enterprise agencies. HHSC is also conducting a regional risk management and safety review for all Enterprise agencies to ensure the safety of both clients and staff.

HHSC has consolidated the warehouse and materials distribution functions for all HHS Enterprise state offices in Austin. HHSC will provide warehouse support services to the state office facilities, perform warehouse safety and security oversight for the state office warehouses, and provide materials distribution services for all five agencies in Austin. This consolidation will help relieve storage capacity problems, provide secure warehouse space for all HHS System agencies' IT operations to stage projects and manage inventories, and provide warehouse space for DSHS Pharmacy storage of pandemic drugs provided through a grant by the federal government. HHSC is also completing development of Enterprise facility management and facility leasing policies and procedures to provide for consistent management of HHS System facilities.

HHSC, in its role providing facility support services to state hospitals and schools, has worked with emergency management officials to enable the system of state psychiatric hospitals to better serve displaced psychiatric patients during an emergency by making beds available in all state hospitals rather than in only one locality. HHSC also worked to revise a federal purchasing process to better enable state hospitals to complete end of fiscal year purchases.

In September 2007, HHSC was one of five winners of the Mega Energy Saver Awards. The Texas A&M Energy Systems Laboratory (ESL) presents the Mega-Energy Saver Award to recipients who have saved more than $1 million in utility costs. This effort sprang from a partnership that started in 2003 among the legacy agency known as the Department of Mental Health and Mental Retardation, ESL, and a comprehensive energy services provider called TAC. In addition to replacing existing equipment and systems with more efficient systems and equipment, other benefits include significant reduction in repair and replacement liability, standardization of certain building systems and procedures statewide, improved living conditions for clients, and better work environments for staff.

HHSC is managing the centralized outsourcing of document output services. This will allow accurate assessment of Enterprise needs, better placement and utilization of equipment, and more cost-effective support. Equipment will come on line as the various local contracts expire. HHSC has established clear standards for performance and clear communication channels for staff to ensure the initiative's success.

Procurement

HHSC is reviewing procurement operations System-wide to ensure that coordination of activities between HHSC and the other System agencies is in place to ensure effective, efficient, and accountable procurements and to ensure appropriate management controls are in place. HHSC is also conducting a "Spend Management Project" to review all Enterprise-wide procurements costs and categories, analyze areas with cost saving potential, and identify categories of purchased goods and services where savings can be achieved.

The toll-free assistance line for Medicaid managed care clients and providers, previously known as STARLink, has been transitioned from a private vendor into the HHSC Office of the Ombudsman and is now known as the Medicaid Managed Care Helpline Unit. The program was created in 1999 to provide informational services to providers and clients, and to help current or would-be Medicaid health maintenance organization clients with health care services. Some of the unit's specific functions include helping people navigate the managed care system, understand their Medicaid coverage, and resolve problems such as access to care. The unit also helps clients change health plans when there's an urgent need, coordinates care when clients move, corrects inaccurate information in client records, and assists clients in getting their prescriptions filled.

Office of Community Collaboration

HHSC has created the Office of Community Collaboration (OCC), bringing together outreach staff in the Medicaid/CHIP Division and the HHS Communications Office to develop a stronger and more coordinated effort to work with community-based organizations and stakeholders to help share best practices and improve agency programs. The OCC has launched several strategic projects designed to help build a statewide system of outreach which include the following:

- The Start the Conversation Project, which will enlist faith-based organizations in HHSC's outreach efforts;
- The Integrated School Based Outreach Initiative, which will increase awareness of the Medicaid and CHIP programs among school district personnel and provide them with appropriate information and tools;
- The PowerPoint Redesign project, which will create uniform materials for OCC outreach activities that support clear and consistent messages about agency programs to internal and external customers; and
- The Medicaid-CHIP Regional Advisory Committee project, which will create regional advisory committees to discuss Medicaid programs and services and to provide HHSC feedback and recommendations.

Contracting

HHSC legal staff has led HHS Enterprise workgroups to improve coordination and consistency of legal approaches to Enterprise contracting activities, rule-making, use of criminal background checks, and ethics policies. In addition, they have worked to improve coordination with the Office of Attorney General in responding to litigation involving multiple agencies in the HHS System and coordinated support for the Legislative Council's anticipated revision of legacy health and human services statutes.

DADS

The Department continues to focus on optimization and transformation phases to address the broader intent of H.B. 2292—to improve efficiency, effectiveness, and integration throughout the HHS System. At DADS, optimization and transformation activities have resulted in benefits and opportunities. Examples of benefits attained include:

- Improved planning and implementation of the agency's receipt of 8,902 slots to reduced the numbers of people waiting to see if they are eligible for services in the 2008-09 biennium;
- Coordinated, consistent, and direct supervision of all licensing activities within one organizational area;
- Expanded quality of life surveys for individuals and family members in all DADS Medicaid waiver and ICF/MR programs;
- Increased oversight and monitoring of regional activities within the DADS Guardianship Program;
- Improved provision of information about the Medicaid Estate Recovery Program to consumers;
- Improved ability to plan and implement a coordinated response when a long-term care provider closes a facility; and
- Enhanced ability to coordinate a response to the implementation of the Medicare Prescription Drug Program, involving the Area Agencies on Aging (AAAs), Mental Retardation Authorities (MRAs), and DADS program staff.

Within the consolidated HHS System, DADS has identified opportunities to create a foundation for future improvements within the DADS system of services and supports. Examples of identified opportunities to further improve DADS services and supports include:

- Applying best practices in clinical quality improvement and provision of evidence-based technical assistance to nursing facilities, state schools, and other contracted facilities;
- Streamlining and standardizing the change-of-ownership processes across institutional services provider contracts to ensure requests are processed efficiently;
- Analyzing the waiver programs to determine if modifications could improve services and supports and increase efficiencies;
- Expanding the Quality Reporting System to include the Home and Community-Based waiver programs;
- Strengthening the provider base for community services by increasing the availability and range of services and supports provided;
- Strengthening further the state school operations management team to increase oversight of day-to-day operations and ensure facilities are using best practices;

- Reviewing policies and processes for enrollment and maintenance of the interest lists to identify opportunities for streamlining and improving processes;
- Reducing duplication of efforts between regulatory oversight and contract monitoring oversight; and
- Streamlining and standardizing processing of contracts.

DARS

Since its inception in 2004, the DARS management team has made a commitment to build a positive working environment. A major initiative has been the DARS Roadmap, a comprehensive approach to planning and tracking the department's progress that stresses world-class services and business practices, constructive collaboration, leadership, and employee empowerment. Other DARS successes are listed below.

Transition Services

DARS created the Business Service Unit to facilitate relationships between employers and the department. Outcomes are better or expanded employment opportunities for people with disabilities. Examples are as follows:

- The new Walgreen's distribution center opening in Houston has committed to hiring up to 50 percent of its staff from DARS referrals of individuals with disabilities;
- Similar relationships are emerging with Comcast, Convergys, CVS and Schwan's:
- Hands on Education and The Hyatt Corporation are expanding the highly successful culinary arts training program for people with disabilities from Florida to San Antonio, Texas, with plans for future expansion in Texas; and
- Hemispheres has committed to hiring people for their new 355,000 square foot distribution center in Coppell.

Child Abuse Prevention and Treatment Act

DARS implemented Child Abuse Prevention and Treatment Act provisions requiring each child younger than age three, who are the subject of a substantiated case of abuse or neglect, to be referred to Early Childhood Intervention for screening/evaluation. DARS also strengthened collaboration with CPS and supported training for CPS and Early Intervention Services staff.

Deaf and Hard of Hearing Services

Following the merger of deaf and hard of hearing services into the Division of Rehabilitation Services (DRS), DARS established 22 contracts in communities throughout the state to provide resource specialists for people who are deaf or have

a hearing loss. Deaf and hard of hearing consumers served by DRS increased from 6 percent of consumers served in 2004 to 9 percent of consumers in 2006. Dollars spent on these individuals increased from approximately $8 million in FY 2004 to more than $9.5 million in FY 2006.

DFPS

Optimization efforts at DFPS were incorporated into a broad agency renewal. Hundreds of improvements were implemented, affecting virtually every area of practice and agency operations. Changes from 2005 to date encompassed all DFPS programs.

Transformation and optimization efforts related to vulnerable adults served by DFPS focused on a core mission of APS. The APS guardianship program was transferred to DADS. A new APS risk assessment tool was developed and implemented, improving the evaluation of a client's living condition, medical status, mental status, financial status, and social support system. The program now assigns complex cases to subject matter experts in abuse, neglect, and exploitation. APS developed a performance management system that improves accountability and allows for greatly improved supervisor monitoring and management of case quality, timeliness, and policy. APS introduced advanced training that enhanced knowledge of mental health and self-neglect and emphasized the importance of working with community organizations, law enforcement, and courts. The programs provided tablet PCs and digital cameras, with mobile software applications, for all direct delivery staff in the APS in-home and facility programs. To make civic connections and mobilize volunteers, APS hired community initiative specialists in each region. The programs made an education stipend available to all APS staff. The stipend encourages caseworkers to attain a higher level of education in APS-related fields and supports workforce retention. APS began a comprehensive evaluation of the APS reform initiatives, a basis for continuous improvement of services to vulnerable Texans. Special task units, multi-disciplinary community teams designed to provide added problem-solving support for complex APS cases, were created in 18 counties with populations greater than 250,000.

Transformation efforts related to children and families have been generated primarily in the CPS program. After implementing new processes to screen job applicants more carefully, CPS filled more than 2,500 new field positions (caseworkers, supervisors, and clerical support staff). The program developed a new investigation model, which includes a stronger risk assessment instrument, new screening procedures for lower priority cases, and training to recognize and respond to high-risk cases. More than 200 special investigators and 49 child safety specialist staff positions were created in the field to assist with CPS investigations and training. CPS caseworker training was expanded to include working with law enforcement, conducting forensic investigations, gathering evidence, upholding fourth amendment rights, drafting affidavits, and testifying in court. CPS implemented statewide a 72-hour response times for Priority 2 investigations, greatly increasing accountability

over the prior policy, which allowed ten days for the maximum response time. Further, CPS began 24-hour casework documentation of critical actions, and CPS designed reports to monitor accountability down to the individual caseworker and unit levels.

As an alternative to paid foster care, the program expanded the statewide kinship program, which provides initial start-up funds and financial assistance to help relative families with child-caring expenses. CPS partnered with communities to start pilot programs in Houston, Arlington, Fort Worth, and Austin to address the disproportionate representation of African American children and other children of color in the child protective services system and specifically in foster care.

Through a competitive procurement process, HHSC awarded a contract for a comprehensive medical, behavioral health, and dental managed care network for children in foster care. The goal is to ensure better accountability for health care outcomes and track children's health care as they move from one placement to another. To ensure health care for youth who age out of foster care, CPS worked with HHSC to implement continuous Medicaid coverage though a single application process until the youth reaches the age of 21. To improve educational outcomes for school-age children in CPS care and to ensure that school records follow each child through placement changes, CPS developed education portfolios. To increase caseworker mobility in the areas of investigations and family-based safety services, and to increase field casework time with clients, CPS distributed tablet PCs and new software. CPS also added resource and external relations specialists in each region, to focus on enhanced service and professional community collaborations.

Transformation efforts related to licensing and regulation include new rules for employees in residential child care operations, requiring:

- Background checks prior to employment,
- Training on prone restraints, and
- Drug testing.

This new rule strengthened minimum standards for residential child care facilities and child-placing agencies and implemented periodic random inspections of foster homes and group foster home. DFPS provided tablet PCs to all direct-delivery staff in the residential child care licensing investigations program.

Agency-wide, DFPS is implementing an accountability and performance management system. The system includes client-centered outcome measures, job performance standards, case reviews, and improved performance reports for management oversight. Case quality and timeliness goals are being consistently integrated into the performance evaluations of all staff, and standardized reporting of program performance metrics are a routine part of executive management's oversight. DFPS employed hiring specialists in each region, instituted a pre-screening test for new applicants, and developed a realistic job preview for

prospective applicants. This has resulted in attracting and hiring individuals more likely to be successful as DFPS caseworkers.

DSHS

DSHS' optimization and transformation activities continue as an important focus of efforts to improve agency operations and outcomes. Below are examples of some of the successes the agency has experienced in the areas of operations, service integration, and mental health transformation.

Operations

In terms of operational successes, DSHS looks for opportunities to consolidate operations where appropriate, such as efforts to optimize administrative functions at the Texas Center for Infectious Disease, the San Antonio State Hospital, the Rio Grande State Center, and the South Texas Health Care System. Most of these consolidation successes occurred shortly after the creation of DSHS, but improvements in this area are ongoing.

In addition to the successes at these facilities, the department has worked to reduce costs relating to pharmaceutical purchasing. Some achievements in this area include:

- Centralization of pharmaceutical purchasing for DSHS medication programs, including HIV/STD, TB, Refugee Health Screening, Hansen's Disease, Women's Health, and the Capitol Nurses Station;
- Consolidation of drug purchases through one contracted drug wholesaler for the DSHS Pharmacy Branch, DSHS State Hospitals, DADS State Schools, and the Texas Department of Criminal Justice; and
- The DSHS Pharmacy Branch has become highly involved in the procurement and management of pharmaceuticals for bioterrorism events, antiviral medications for pandemic flu, and supplies for hurricanes and other natural disasters

These activities result in cost savings to DSHS programs because of volume discounts and/or administrative savings. In some cases, timeframes for medication distribution is also much improved.

Service Integration

In FY 2008, DSHS initiated a planning process designed to assess the agency's capacity and readiness for integrating primary and behavioral health services. As a result, a plan will be developed to serve as the foundation for integrating services that address overall health and well-being. As part of this effort, DSHS will pursue opportunities to work in collaboration with other state and local entities involved in similar initiatives. Methods for achieving integration will focus on improved service

coordination and adoption of approaches that holistically address the needs of individuals receiving DSHS-funded services.

A formal planning process is now underway, and it will build on DSHS' integration-related projects in place over the past few years. For example, the Division of Family and Community Health Services and the Division of Mental Health and Substance Abuse Services have partnered with academic, private, public, and other health care communities to create the *Texas Adolescent Mental Health in Primary Care Initiative*. DSHS contracted with Texas Tech University Health Sciences Center to design and implement the feasibility study to evaluate an adolescent behavioral health screening and intervention model in five diverse primary care settings. Protocols include screening, referral, and treatment for a full spectrum of psychosocial health and substance use or abuse. Data from a feasibility study has been collected. Results will be analyzed and evaluated in consideration of a plan for design of the full-scale comparative study in the future.

Another success is Texas Health Steps on-line provider education, a campaign on which DSHS and HHSC collaborated. The educational modules offer free continuing education credits. The targeted audiences for the educational Web site include: physicians, nurses, nurse practitioners, physician assistants, dental hygienists, pharmacists, dentists, social workers, mental health professionals, and health educators. Efforts are underway to develop modules on the following topics:

- Mental Health Assessment,
- Development Assessment,
- Cultural Competency,
- Adolescent Health and Transition Services, and
- Obesity.

Mental Health Transformation

In FY 2006, the Texas Governor's Office was awarded a *Mental Health Transformation State Incentive Grant* from the U.S. Substance Abuse and Mental Health Services Administration. This five-year initiative serves as a catalyst for adopting the types of cross-agency reforms needed to improve the health and well-being of Texans with behavioral health needs. The success of this effort relies on the development, maintenance, and sustainability of inter-agency partnerships among:

- State and local agencies that procure or directly provide behavioral health services;
- Advocacy organizations;
- Service recipients and their families; and
- Other stakeholders.

Two priorities for the effort include the development of consumer- and family-driven communities of care, and the use of state-of-the-art technology as a cross-systemic method for service coordination.

Ensuring Stakeholder Input in the Consolidated Environment

In creating and operating the revamped HHS System pursuant to H.B. 2292, ensuring the involvement and input of stakeholders has been of great importance. As the new HHS System was being designed in FY 2004, stakeholder input was obtained by the Transition Legislative Oversight Committee through a series of hearings held in different parts of the state. More than 1,700 people attended those hearings.

One of the key H.B. 2292 provisions relating to stakeholder involvement was a requirement that a nine-member agency council be appointed by the Governor for each agency, for providing advice and input to agency leadership and for representing the perspective of diverse stakeholders. The agency councils all meet on at least a quarterly basis.

Each agency has also structured other mechanisms for receiving stakeholder input and sharing information with stakeholders. These specific approaches are discussed below.

HHSC

In 2007 the HHSC Council formed subcommittees to focus on two major issues: eligibility systems, and Medicaid reform and hospital financing. These sub-committees provided an opportunity for the Council members to hear from stakeholders and to provide guidance on the Health Care and Medicaid Reform project and the transition to the new eligibility system.

In addition to Agency Council activities, HHSC holds a bimonthly public stakeholder forum that encompasses all HHSC programs and projects. The forum is held on the second Monday of every other month. The forum topics are repeated a few days later in a desktop version of the forum, which is conducted in a conference call format. This desktop forum allows stakeholders who live outside the Austin area the same opportunity to receive presentations about updates on HHSC programs and initiatives. Both forums are interactive and provide an opportunity for questions and answers (Q&A).

In addition, there is a section of the HHSC Web site (www.hhsc.state.tx.us/stakeholder) that is dedicated to communicating with stakeholders. On this Web page, HHSC posts the agenda for the stakeholder forum and a Q&A form that can be used to submit questions. Questions are answered

individually, and responses can be posted to the Web page. HHSC also posts questions and answers from the forums in the Q&A section. The Web page also includes links to a bimonthly HHSC newsletter, *In Touch*, which contains articles about HHSC programs.

To keep updated on new information posted to the HHSC Web site, individuals can sign up for a notification system that will send them an e-mail when sections of the Web site in which they are interested have been updated.

In addition to these regular, formal communications efforts, program staff works with interested stakeholder groups in developing policies and programs. The relationships vary from formal to informal, as HHSC works with stakeholders to achieve the mission of the agency.

DADS

The Stakeholder Relations Unit in the Center for Consumer and External Affairs supports the DADS Agency Council that uses stakeholder input to inform its advisory role. The unit supports the Agency Council and coordinates with executive administration staff in keeping Agency Council members apprised of DADS issues and activities through the implementation of mid-council reports.

The Stakeholder Relations Unit responds to constituent issues from legislative offices and coordinates activities with DADS Client Rights and Services, DADS Long-Term Care Ombudsman, and HHSC Ombudsman. In addition, the Stakeholder Relations Unit develops the Department's Compact with Texans, a legislatively required document that outlines consumer service principles, standards, and practices, and ensures the active participation of DADS in the HHSC biennial Customer Service Survey.

The Department's stakeholders have been encouraged to participate in the Strategic Plan and Legislative Appropriations Request development processes. Like other HHS System agencies, DADS has implemented electronic notification of stakeholders regarding revisions to and clarification of DADS policies. Multiple opportunities and forums, such as on-line input, public hearings, and videoconferences with multiple locations around the state, ensure stakeholder input is sought and reflected in these documents, which guide the future of DADS.

DARS

Input from stakeholders is extremely important to DARS. The DARS Center for Consumer and External Affairs has a number of activities that are used on a regular basis to communicate relevant information with stakeholders. These activities include distribution of information to appropriate stakeholder groups through e-mail and a stakeholder Internet site. DARS is also promoting the use of an e-mail notification system so updates to the agency Web site and other electronic media

are available in a timely manner. This service allows the public to "subscribe" to certain Web pages and receive updates. DARS also holds public forums on a regular basis to receive input from stakeholders on specific topics. DARS has a process to review the information received from stakeholders and to communicate back to stakeholders on follow-up actions. It is a fundamental value of DARS to listen, to learn, and to be responsive to DARS stakeholders and consumers in an ongoing effort to make programs and services even better.

DFPS

DFPS recognizes that building community relationships and partnerships is integral and critical to providing clients with services. Reform efforts have focused on providing information to and soliciting input from internal and external stakeholders; DFPS has a comprehensive strategic plan for community engagement and coordination strategies to achieve desired outcomes for clients and families. Efforts to increase public awareness and to promote involvement occur both on a local level and at the program level. Local relationships have included partnerships with boards, such as the currently-developing Texas Partners for Adult Protective Services State Board, to stock emergency resource rooms.

The DFPS commitment to engaging the community has led the agency to strengthen its partnering and communication efforts. DFPS invites the public to participate in a quarterly stakeholder forum, which is a two-hour meeting with three goals:

- Presenting information regarding present or future departmental changes;
- Soliciting honest, helpful feedback pertaining to changes; and
- Gathering suggestions for future stakeholder forum topics to ensure that the forums are mutually beneficial to stakeholders and DFPS.

Stakeholder forums are posted on the DFPS Web site under "News," and e-mail notification is sent to stakeholders who have subscribed to this HHSC service. An e-mail address, stakeholder@dfps.state.tx.us, has been created for stakeholders who are unable to attend the forum but wish to contribute.

DFPS communicates weekly with its Advisory Council, notifying members of public hearings and other regional meetings, events, or news items of interest. Council meetings provide an additional opportunity for DFPS to receive stakeholder input in the form of public testimony, and rule changes are posted prior to each council meeting, allowing for written public comment.

Separate from the quarterly stakeholder forums, DFPS holds a stakeholder meeting on the Legislative Appropriation Request process. Public testimony on the potential exceptional items for the upcoming fiscal year is welcome at this meeting.

Increased stakeholder awareness has also been achieved through the recently updated DFPS volunteer Web page, which offers several volunteer opportunities

and information on how to get started. Finally, DFPS is developing computer-based training (CBT) for staff on ways to engage clients, families, providers, officials, and other partners in all aspects of DFPS work.

DFPS has solicited stakeholder input on all major projects resulting from reform and optimization efforts, including:

- Case management outsourcing,
- Development of a medical services network for children in foster care,
- Expanding early intervention services for prevention of abuse and neglect,
- Strengthening child care licensing standards,
- Improving the quality of investigations of potential abuse and neglect, and
- Enhancing poverty-related services for families.

DSHS

As part of planning, decision-making, rule and policy development, service system design, and other key functions, DSHS uses a number of approaches for communicating with and seeking input from stakeholders. Efforts are made to use methods that enable broad participation from individuals, organizations, groups, advocates, policy-makers, service providers, and the general public. Examples include formal and informal meetings, conference calls, list serves and other types of technology. Underlying the DSHS stakeholder engagement strategy is the department's commitment to partnerships and the recognition that government alone cannot improve the health and well-being of Texans.

The DSHS Council is appointed by the governor and is integral to the stakeholder engagement process. DSHS also has many other program-specific advisory committees that play a role in making sure that external input is included in policy-making. Both the council and the various advisory committees provide opportunities to share information about agency issues and activities. In addition, stakeholder forums are an essential element of the agency's rule-making and policy development process. These forums serve as opportunities for stakeholders to inform DSHS about rules and policies that have a direct effect on their lives or their businesses. This process for informing decision-making assists DSHS in creating rules and policies that are presented to the council and then implemented by the agency.

In addition to these more formal processes, DSHS program areas have established relationships with stakeholder groups that are interested in DSHS activities and policy issues. Stakeholder relations occur most frequently at the program level. This can occur through large multi-stakeholder meetings, or through one-on-one communications between service areas and individuals. Regardless of the nature of the issue or the formality of the process, the relationships that have been built

between stakeholders and agency staff help DSHS to operate effectively, with sensitivity to the impact of decisions on constituents.

DSHS also uses technology to maintain consistent contact with stakeholders. This occurs through an e-mail notification system that informs interested individuals when new information is posted on department Web sites. Stakeholders receive the e-mail notifications after subscribing to the service through the DSHS Web site. Individuals self-select the type of information they want to receive.

Finally, DSHS responds to customer service requests submitted by mail or electronically as well as to constituent issues from legislative offices. These requests are coordinated internally at DSHS and with other Enterprise agencies as needed.

Challenges and Opportunities in the HHS System

As a populous and geographically expansive state with a large poverty population and major health issues, Texas faces unique challenges in delivering an interconnected array of health and human services. During the strategic planning process, each HHS System agency reviewed its major challenges and opportunities. Workforce challenges, associated with retirements, turnover, and shortages in specific job titles, are discussed in The HHS Enterprise workforce plan, Appendix F, which presents a system-wide plan for addressing these issues. Other challenges and opportunities common to the HHS System are discussed below. Challenges and opportunities specific to a particular agency are discussed in that agency's chapter of this document.

Disaster Response and Preparedness

When a catastrophic incident occurs in Texas and the state's assistance is requested, HHS Enterprise agencies work together to respond to the demands of the particular situation. Given the size of the state and the complexity of health and human service delivery, especially in a disaster situation, coordination is essential for a prompt and effective response. Coordination occurs at the local, regional, and state levels.

In 2006, HHSC formed the Emergency Management Council (EMC) in accordance with Goal 1, Objective 1.1 of HHSC's Homeland Security Strategic Implementation Plan. The EMC includes key representation from HHS System agencies and focuses on HHS System continuity of operations and infrastructure recovery, and it provides oversight of emergency management and public health preparedness

efforts of HHS System agencies. The EMC will ensure consistent and constant communication with, and provide strategic coordination to, the HHS System agencies in the event a disaster affects the HHS System infrastructure. The EMC coordinates the completion and filing of HHS System agency emergency management documents requested by the Governor's Division of Emergency Management (GDEM) and other state or federal agencies. The EMC meets monthly to address issues related to emergency management and continuity of operations.

Current areas of interest and recent policy attention include:

- Implement and helping coordinate the final recommendations of the workgroup formed subsequent to the Enterprise Emergency Management Memorandum of Agreement;
- Pandemic influenza preparedness; and
- Continuity of operations planning of each HHS System agency.

The EMC created the Business Continuity Planning Workgroup, comprised of continuity of operations planners from each HHS System agency and led by the director of Enterprise Risk Management and Safety, to establish authority of continuity if operations planners to identify, request, and define the requirements for establishing the labor resources within each agency division, department, and/or unit to be responsible for assisting the business continuity planner in the development and ongoing maintenance of the recovery plan. This workgroup meets monthly to share information and processes so that the Enterprise will have a consistent approach to continuity of operations planning. All HHS System agencies are required to develop continuity of operations plans (COOPs) to define how the agencies will continue business operations or recover their critical business functions in the event of an unplanned business disruption or major interruption to essential health and human services deliverables.

In the summer of 2007, the Governor created a state-level Pandemic Preparedness workgroup to better prepare for a pandemic influenza outbreak in Texas. The workgroup has drafted policy recommendations to maintain continuity of critical operations and services by state agencies during an influenza pandemic outbreak in the U.S.

Hurricanes Katrina and Rita in 2005 shifted paradigms in preparedness and response, particularly in systems of health and medical care service delivery. Practically overnight, the importance of coordination of care grew from a challenge to an imperative. The severe weather events of 2007 showed vast improvements in response capabilities by HHS System agencies, individually, collectively, and in coordination with both public and private partners.

DSHS

DSHS is the lead agency for coordinating health and medical preparedness and response activities, such as medical special needs evacuations and public communications about personal health protection. These preparedness and response activities address not only public health and medical services, but also nuclear and/or radiological incidents. DSHS continues to strengthen its readiness to respond during an emergency and to fulfill the role of coordination, while ensuring the continuity of operations for mission-essential day-to-day functions the agency performs.

DSHS activities following the Eagle Pass Tornado of April 2007 included the establishment of an on-site mobile medical command post. A public health team assessed health needs and secured medications for displaced residents, collected injury and death data, and delivered Tetanus vaccine to first responders. A sanitarian team monitored food and water safety at three shelter areas, and a crisis counseling team offered support. DSHS worked with the Texas Commission on Environmental Quality to get the wastewater treatment facility back on line.

The Multi-Agency Coordination Center (MACC), an HHS System operations center for health and medical response, was activated to assist Health Service Regions with Central Texas flooding between June and August 2007. Disaster mental health and critical incident stress management teams, particularly in the Marble Falls area, provided Tetanus vaccine, medical equipment, hand sanitation supplies, and resources for water testing. Subject matter expertise in vector control was provided, as well as medical support of shelters.

The MACC was also activated in August 2007 in anticipation of the threat posed by Hurricane Dean. HHS System agencies worked closely with the Governor's office and other state and federal partners in preparation for the hurricane to make landfall. Plans were assembled and resources were secured to perform air evacuations of both critical and non-critical patients. Vacant hospital and nursing home beds were assessed throughout the state and the need for two federal medical stations was determined. Portable oxygen supplies were secured for citizens who would evacuate by automobile, and medical staff and supplies to accomplish the conversion of school buses to medical transport vehicles were quickly assembled through emergency purchase procedures. Fortunately, what could have been the nation's largest medical evacuation turned into the state's biggest medical evacuation exercise to date, providing valuable information and experience.

A month later, in September 2007, Hurricane Humberto primarily impacted Beaumont, Crystal Beach, Port Arthur, and parts of Jefferson County. Power outages resulted in numerous problems for individuals with medical special needs, and DSHS Health Service Region 6/5 South coordinated response activities to assist local communities until power could be restored.

DADS

Hurricanes Katrina and Rita presented extraordinary challenges to DADS. Rapid response was the strategy that DADS took to deal with the hurricane impacts during the months of August and September 2005. The agency focused on the health and safety of consumers. The principles that guided DADS were:

- Making decisions based on the needs of consumers,
- Preventing delays in service delivery,
- Revising or waiving rules and regulations that were potential barriers to Ensuring the health and safety of consumers, and
- Involving regional staff immediately in making decisions at the local level when possible.

The agency worked to ensure the safety of consumers in nursing facilities, state mental retardation facilities, ICFs/MR, and consumers served through contractors, primarily home health care providers.

The agency identified problems and issues through calls or emails received directly at DADS and through communications with the State Operations Center (SOC) and the DSHS Emergency Support Center, both of which provided 24-hour coverage. In addition, designated staff from DADS staffed these centers and was on call around the clock at both state office and regional offices.

Partnering with other organizations and state agencies, DADS took a variety of actions, including providing information on the DADS Web site for health care providers. The AAAs coordinated with DADS regulatory staff and nursing facilities to identify available bed space. The agency staff, the AAAs, and the MRAs assisted in the assessment of populations in shelters.

The agency and the organizations it partners with in providing services are engaged in planning for responses to possible future large-scale major disasters. The agency sees the key to success in this planning as the establishment and maintenance of partnerships at all levels.

Since the events of 2005, DADS has developed a Web-based tracking system called FIVES (Facility Inventory, Vacancy, and Evacuation Status) that assists nursing facilities in locating available beds throughout the state during emergencies that require evacuations.

The agency continues to work with the Transportation Committee in the Office of the Governor to develop evacuation strategies that ensure adequate transportation capabilities for long-term care residents in emergencies.

HHSC

HHSC responds to disaster efforts through several of its programs, coordinating with the other Enterprise agencies, the Governor's Office, and other state and federal agencies, to serve the health and safety needs of the public.

Emergency Services Program Disaster Assistance

HHSC processes applications for grants to people who have serious needs and necessary expenses associated with presidentially declared disasters, such as floods, hurricanes, and tornadoes. Victims of such disasters are eligible for assistance from the Other Needs Assistance (ONA) provision of the Federal Assistance to Individuals and Household Program (IHP) if they do not have insurance and can not qualify for low-interest loans from the Small Business Administration. ONA grants are paid with 75 percent federal funds and 25 percent state funds from the Governor's Disaster Contingency Fund. The Department of Homeland Security oversees the Federal Emergency Management Agency, which administers the Housing Assistance (HA) provision of the Program. The IHP maximum grant (ONA and HA) is $28,800 and is adjusted annually based on the Consumer Price Index. The Emergency Services Program is also charged with coordinating with other state agencies and volunteer organizations to provide water and ice to communities hit by a disaster.

Additionally the program is responsible for developing and implementing the Texas State Emergency Plan for Emergency Repatriation. Emergency repatriation occurs when a large numbers of U.S. citizens must be returned from a foreign country due to war, threat of war, or natural disaster. Repatriates who need assistance returning home are eligible for funds provided by the U.S. DHHS.

Direct Service Delivery

HHSC directly provides the following disaster-related services:

- **Texas Information and Referral Network (2-1-1)—**The Texas Information and Referral Network (TIRN) is a comprehensive statewide information and referral network whose mission is to provide callers with information about health and human services on the local, regional, state, and national levels. When a person dials 2-1-1 on the telephone, a professional information specialist provides referrals to meet the caller's needs. TIRN has a contract with the GDEM to provide information and referral services during disaster events and to serve as the initial point of contact for the Transportation Assistance Registry, which coordinates efforts to help people with special needs evacuate before a disaster.
- **TANF—**HHSC processes applications for short-term, non-recurring TANF assistance funded by a federal allotment.
- **Food Stamps—**HHSC certifies evacuee households for food stamp benefits, sending staff and equipment to shelters and the Disaster Recovery Centers in Houston, Dallas, San Antonio, Austin, Beaumont, and Fort Worth.

- **Family Violence Services—**This division provides shelter, transportation, and counseling services through local shelters.
- **Vendor Drug Program—**Staff guides Texas pharmacies on how to fill prescriptions for evacuees with Medicaid.
- **Medicaid Waiver—**HHSC works with the Centers for Medicare and Medicaid Services (CMS) to obtain Medicaid waivers ensuring that evacuees have access to medical services.

DFPS

DFPS recognizes that unexpected disruptive events—natural disasters, equipment failures, and man-made disasters—can interrupt service delivery and business processes. Based on lessons learned from experience during and after Hurricanes Katrina and Rita, DFPS created a business continuity plan to ensure essential services are maintain in affected areas. Through continuity of operations planning, DFPS is preparing for possible disruptive events, to ensure that, in the event of a disaster condition, the agency can provide at least a minimum level of service within a predetermined period of time, as the rest of the organization is being restored (recovered) to business as usual.

A COOP contains the procedures that define how an agency will continue or recover operations in the event of unplanned, extended disruption of normal operations. Business continuity plans are in place for the each DFPS program and support area, to ensure that DFPS as an organization will survive a disaster and continue normal business operations. Each plan is updated at least annually. DFPS continues in the process of business continuity planning through ongoing identification of key business functions and systems of each of its program and business areas. The agency also continues to assess the impacts that could result from the loss of each function and system.

In its field offices, DFPS communicates with providers to assess available bed space, serves a case management role in shelters, organizes local donation drives, establishes safe and adequate child care in shelters, and works with other Enterprise agencies to assist victims with special needs. DFPS is also an active partner and contributor of resources to the MACC, which is the Enterprise operations center for health and medical response, and the SOC, which is operated by the Department of Public Safety. DFPS will continue to build capabilities to prevent, protect against, respond to, and recover from all threats to the agency, its staff, and clients.

DARS

Although DARS is not an emergency services agency, the agency still contributes to disaster relief efforts. During Hurricanes Katrina and Rita, DARS assisted in efforts to supply Texas shelter sites with wheelchairs and other durable medical equipment

for people with disabilities. To help expedite service delivery according to HHSC guidance, DARS has waived certain program eligibility criteria, such as residence and identification criteria in the case of evacuees. DARS also assists in locating interpreters for evacuees across the state.

Coordination of Services for Acquired Brain Injury

The newly established Office of Acquired Brain Injury was authorized to assist and coordinate services for people with acquired brain injuries and their families, including returning veterans. A person with acquired brain injury may have problems functioning in multiple domains, including physical (e.g., mobility, vision, sleep); language (e.g., speaking and/or understanding language), cognitive (e.g., memory, problem-solving, organization, attention); behavioral-emotional (e.g., control of impulses, initiating activity, controlling mood or temper, paranoia); or psychosocial (e.g., getting along with others, social judgment).

People with brain injuries require a wide range of state-supported services. To serve these people effectively, services must be coordinated in a comprehensive way. Among the agencies that provide the wide variety of services are:

- HHS Enterprise (Medicaid primary health care, long-term care, vocational rehabilitation services, food stamps, and adult and child protective services;
- Texas Education Agency;
- Texas Veteran's Commission;
- U.S. Department of Veterans Affairs;
- TWC; and
- Texas Department of Housing and Community Affairs.

The Office of Acquired Brain Injury looks comprehensively across the Enterprise and coordinates services in the Enterprise and beyond. Challenges for this office include:

- Providing information and support to victims and families;
- Coordinating existing state and federal services; and
- Ensuring policy changes are based upon accurate data and assessments.

Opportunities for this office include:

- Partnering with the U.S. Department of Veterans Affairs to ensure that specialized services are provided to returning Texas soldiers;
- Securing grants to expand the opportunities to serve individuals with acquired brain injury;
- Developing the ability to facilitate access to services through the office as well as other venues like the 2-1-1 TIRN;

- Securing memoranda of understanding with other state agencies to provide a coordinated system of services for individuals with acquired brain injury; and
- Seeking grants to enhance prevention efforts as guided by the Traumatic Brain Injury Advisory Council, a 21-member council appointed by the HHSC Commissioner to advise state leadership on policies and programs affecting people with brain injury and their families.

Coordination of Long-Term Services and Supports

With the consolidation of the HHS System agencies in 2003 and the expansion of Medicaid managed care delivery systems that incorporate long-term services, there is an increased need to ensure that the delivery of long-term services and supports (LTSS) is coordinated between programs operating in DADS and in HHSC.

DADS, as the LTSS agency, develops Texas LTSS policies for implementation in DADS programs. As much as possible, policies for HHSC-managed LTSS programs mirror DADS policies. LTSS coordination efforts between the agencies have increased in scope and importance with expansion of the STAR+PLUS system of delivery of integrated health services, the implementation of the Integrated Care Management model, and the introduction of Consumer Directed Services in both DADS and HHSC programs.

HHS-Circular C-015 established an Enterprise executive workgroup to provide high-level coordination for managed care integration issues and to address operational issues that affect individuals using long-term services and supports. Ongoing coordination among the agencies, both by this workgroup and in forums with stakeholders, remains vital.

Guardianship Program Coordination

There is an increasing need for guardians for incapacitated individuals. Guardians are needed to exercise a wide range of responsibilities, such as managing estates, making medical decisions, and arranging for residential care. More than 1,041 clients of DFPS benefit from the guardianship program administered by DADS. DADS may seek guardianship over two client populations referred by DFPS:

- Incapacitated children aging out of DFPS conservatorship; and
- Incapacitated adults determined by DFPS to be in a state of abuse, neglect, and/or exploitation.

Increasingly, advocates seek to appoint DADS as guardian for people who are incapacitated without suitable family, even if they are not at risk of abuse, neglect, and/or exploitation.

HHSC has statutory authority and has received legislative appropriations since 1997 to make grants to local guardianship and money management programs that serve as guardians or money managers. This HHSC program seeks to increase the availability on a statewide basis of guardians needed by incapacitated persons who have no family or friends or funds to provide those services. The HHSC guardianship program seeks to improve the availability of guardians by:

- Supporting the 15-member HHSC Guardianship Advisory Board, created under Government Code, Section 531.122, et seq., to advise both HHSC and DADS on statewide guardianship policies of all HHS System agencies;
- Developing an annual statewide plan for improving the availability of guardians for incapacitated individuals who need them;
- Administering grants for local guardianship and money management programs under Government Code, Section 531.125;
- Using an interagency steering committee to coordinate the HHSC guardianship program with the guardianship program administered by DADS for the benefit of clients referred by DFPS; and
- Working with the guardianship certification program which was established at the Office of Court Administration.

At the end of 2007, the local guardianship programs that received grants from the HHSC guardianship program had provided guardians for 2,287 individuals needing assistance.

With input from the HHSC Guardianship Advisory Board, and in close partnership with DADS, the HHSC guardianship program will continue to identify options and solutions to ensure that incapacitated individuals can find an appropriate and qualified guardian when one is needed.

Implementation of a System of Psychiatric Treatment Alternatives for Children

Many times, children in the conservatorship of DFPS remain in public and private psychiatric hospitals after the medical need for continued inpatient treatment has ended. This delayed stay is caused by the lack of appropriate residential and other placement options.

Multiple interagency groups have convened to address this issue, and some progress has been made, including collaboration with the Waco Center for Youth, operated by DSHS. In addition, multiple programs and funding streams under HHSC, DFPS, and DSHS provide services to these youth. Texas Medicaid will begin a specialized program for youth in foster care in the spring of 2008.

Additional strategies could result in improving outcomes and reducing long-term costs for children in psychiatric and residential care. Possible strategies include:

- Implementing the Psychiatric Residential Treatment Facility option under Medicaid;
- Providing intensive, in-home services to help youth return to or remain successfully in the home; and/or
- Helping them become healthy enough to be released from state custody permanently.

Typically, residential treatment providers offer little in the way of measurable, long-term outcome data, i.e., measures of these children's well-being over time, not just a count of how many beds the state has purchased. Proposed goals of this alternative treatment system include increasing providers' accountability for producing outcomes, and maximizing federal matching dollars for current and new service strategies.

Communications Accessibility across the HHS Enterprise

Persons with limited English proficiency (LEP) and people with sensory or speech impairments often experience barriers in communication. The projected increase in these two populations, as well as caseload growth rates, indicates that a significant proportion of future applicants to and participants in HHS System programs will likely require communication assistance services in order to navigate effectively through the HHS System.

HHS System agencies are mandated under state and federal civil rights laws and guidelines to provide meaningful access to programs, services, and activities for clients with communication challenges. Each HHS System program, activity, and provider must ensure access to services by enabling all persons to communicate with the agencies. This requirement includes timely access to telecommunications and electronic information about agency programs and services.

HHS System agencies have worked to provide communication assistance to applicants and participants. Examples of accomplishments include the following:

- Implementing the language services policy;
- Implementing the electronic and information resources accessibility policy that will ensure accessibility for employees and members of the public who are LEP and who have sensory and speech impairments;
- Contracting with providers for over-the-phone interpretation services and publicized the services widely throughout the agencies, so employees are aware of how to access services;

- Awarding contracts for interpretation and translation services and for interpretation services for the deaf and hard of hearing; and
- Providing an avenue, through the civil rights client complaint process, for applicants and participants to raise issues about barriers to communication.

HHS System agencies and their contractors will continue to provide communication assistance. Some of the activities the HHS System agencies will undertake to remove barriers and improve access include the following:

- Improving ways to use bilingual staff in communicating with applicants and participants when seeking services;
- Monitoring contracts and developing standards for over-the-phone interpretation services, other interpretation services, and interpretation services for the deaf and hard of hearing;
- Working with contractors to ensure their services meet compliance standards for effectively communicating with the public with LEP and sensory impairments;
- Working with the Department of Information Resources to comply with legal standards for agency Web sites, Interactive Voice Response systems, interactive Web-based application processes, Voice-Over-Internet-Protocols, and other telecommunication and electronic resources;
- Continuing implementation of electronic and information resources policies and procedures to ensure effective communication with individuals with sensory impairments;
- Providing auxiliary aids and services to individuals with visual and other sensory impairments;
- Including communications accessibility in the civil rights CBT for all employees, and
- Preparing language service plans for each agency.

Establishing a Common Regional Framework and Consolidating Regional Support Services

More than 75 percent of HHS System employees work outside of Austin, in approximately 1,200 facilities across the state. An integrated regional structure for delivering health and human services offers the opportunity to improve both the quality of services and the cost-effectiveness of delivering them. Consolidating administrative staff and combining offices enable efficiencies regarding lease payments, utility services, administrative service contracts, phone systems and lines, postage accounts, and leased office equipment, and bulk office supplies.

An initial step in consolidating administrative services was to standardize the HHS Enterprise regions. Before the 12 legacy health and human services agencies were

merged by H.B. 2292, they used a variety of regional boundaries. Some agencies used regional boundaries consistent with the existing 11 HHS Enterprise boundaries. Other agencies used a modified structure that combined some of the 11 HHS Enterprise regions. Still other agencies used regional boundaries that were inconsistent with the HHS Enterprise boundaries.

To better provide administrative services at the regional level, in September 2004, 10 HHS Enterprise regions were adapted from the prior 11-region concept, with Regions 2 and 9 combined, as illustrated in Figure 3.13.

Figure 3.13
HHS Administrative Service Regions

Figure 3.13: HHSC Strategic Decision Support, 2006.

Each region currently has a Regional Administrative Service Center. Administrative services are being delivered at the regional level by the Regional Administrative Service Center via an integrated service delivery system supporting all HHS Enterprise agencies. This approach, in addition to providing administrative

efficiencies, is reducing the effort program staff must expend on support and administrative functions. Standardized policies and procedures for administrative operations are being developed for all regions. Administrative contracts are now being developed for the HHS System, rather than for individual agencies.

Regional administrative functions currently include facility management and leasing, facility operations, asset management, administrative contract management, budget, purchase requests, payments, receivables, and health and safety. Regional administrative support services are provided to HHSC, DADS, DFPS, DARS, and DSHS.

Recent State and Federal Policy Direction

The HHS System is frequently affected by changes in federal or state law, as well as federal executive branch policy direction in the form of administrative rules. This discussion highlights several of the most significant recent actions providing policy direction to HHS System agencies.

State Policy

Several pieces of legislation enacted by the 80th Legislature, Regular Session, 2007, will have fundamental impacts on HHS System programs. Additionally, the 2008-09 General Appropriations Act (GAA) provides additional funding for these pieces of legislation and all programs in the HHS System.

Medicaid Budget

The GAA includes $39.5 billion for Medicaid, which accounts for 26 percent of the state's total budget. The program provides health coverage for one out of every three children in Texas, pays for more than half of all births, and covers two-thirds of all nursing home care. Children make up approximately two-thirds of the state's Medicaid caseload. However, services to clients who are elderly or have disabilities account for two-thirds of the program's costs. Major legislative decisions about the state's Medicaid program include the following policy changes.

- Appropriating $707 million in general revenue ($1.8 billion all funds) for an agreement in the *Frew* lawsuit over utilization of preventive services by Texas children who have Medicaid. Most of the additional funding ($512 million in general revenue) will be used to increase payment rates for dentists, physicians, and specialists: rates for dentists will increase 50 percent, and rates for physicians and other health professionals will increase an average of 25 percent.

- Adding $184 million in general revenue for caseload growth, as Medicaid is projected to serve 2.9 million Texans per month in FY 2009, an increase of more than 100,000 clients from current caseload levels.
- Increasing provider rates for Medicaid acute care programs not covered by the *Frew* agreement. These increases include a 10 percent increase for physicians, a 25 percent increase for dentists, and increases for home health providers, ambulance services, pharmacy services, and primary care case management fees.
- Increasing rates for long-term care providers: a 9 percent increase for ICFs/MR, a 6 percent increase for community care providers, and an average 3 percent increase in FY 2008 and 5 percent in FY 2009 for nursing facilities.

Health Care and Medicaid Reform

S.B. 10, 80th Legislature, Regular Session, 2007, provides direction for a comprehensive package of Medicaid reforms designed to focus on prevention, emphasize individual choice, and increase the percentage of Texans with health care coverage. The bill authorizes a Health Opportunity Pool (HOP) to provide federal dollars for health insurance subsidies to low-income individuals. The HOP also allows Texas to leverage and maximize federal dollars to reimburse hospitals for uncompensated care and to reward local entities for implementing innovative measures to provide primary and preventive care. The bill requires HHSC to initiate a pilot program to reward healthy behaviors, such as completing weight loss or smoking cessation programs. The bill requires premium payments for employees who are Medicaid eligible but choose to enroll in employer-sponsored health insurance, and program infrastructure improvements such as encouraging the development and use of electronic health information standards and electronic health records to improve patient care. Medicaid coverage is extended to age 23 for young adults who were formerly in foster care and are attending college. Finally, the bill authorizes tailored benefits packages for children with special health care needs, to meet the complex needs of this population.

Children's Health Insurance Program

The 80th Legislature approved $2 billion in funding for CHIP, a $1 billion increase compared to 2006-07 funding levels. This amount includes $698.5 million for the new CHIP perinate coverage, which expands the availability of prenatal coverage in the state. The perinate coverage, which began in January 2007, also provides CHIP coverage for the baby after birth. The CHIP eligibility limit is maintained at 200 percent of the FPL, the same level since the program's inception in 1999.

H.B. 109, 80th Legislature, Regular Session, 2007 extended CHIP coverage to one year, eliminated the 90-day waiting period, allowed families to deduct child-care expenses, and expanded the asset limits for the program. Families earning more than 185 percent of the FPL will have an income review at their sixth month of

coverage. HHSC estimates these changes will increase CHIP enrollment from 300,262 children at the end of FY 2007 to more than 500,000 children by the end of FY 2009, approximately a 65 percent increase.

Child Protective Services Reform

The 80th Legislature approved $100 million in general revenue and federal TANF funds for implementation of S.B. 758, to build on the CPS reforms initiated by the 79th Legislature. The legislation seeks to keep families together while ensuring child safety in the home, to reduce the length of time children remain in state care, and to improve the quality and accountability of foster care. Some of the significant initiatives in the bill include:

- Expansion of the Family Group Decision Making model,
- Establishment of the Strengthening Families through Enhanced In-Home Support pilot program, and
- Reduction of caseloads for family-based safety services caseworkers and substitute care caseworkers.

Interest List and Waiting List Reduction

The 80th Legislature provided $107 million in general revenue to reduce interest lists and waiting lists at several agencies during the 2008-09 biennium. The funding will cover approximately 8,900 more clients at DADS, 975 more clients at DSHS, and 350 more clients at DARS.

Mental Health Services

Funding for crisis mental health services increased by $82 million in general revenue. The additional funding provides for opening six new psychiatric emergency observation sites, providing children's outpatient and crisis stabilization services for 87,000 children, and training and certifying 340 community center staff to respond to crisis calls. Funding for state mental health facilities totaled $634 million, providing for the average daily census of the mental health facilities to increase from 2,237 clients in 2006 to 2,477 in 2008 and 2009.

State Schools

The 80th Legislature appropriated for the 2008-09 biennium an additional $48.8 million in general revenue to allow DADS to hire 1,690 employees to improve staff-to-resident ratios at state schools. In addition, 250 additional Home and Community-Based Services slots will be available to eligible state school residents who choose to move to community settings.

Federal Policy

Several administrative actions and programs are currently under development by the federal government, directly impacting programs in the HHS System.

Health Care and Medicaid Reform Waiver

S.B. 10 directed HHSC to seek a waiver from CMS at the U.S. DHHS. The waiver was submitted to CMS on April 16, 2008, and outlines the state's plan to expand health coverage options, to reduce reliance on expensive emergency room visits for basic care, and to make it easier for the working poor to buy into employer-sponsored coverage.

Payment Error Rate Measurement Project

CMS instituted the Payment Error Rate Measurement Project to measure improper payments in the Medicaid and CHIP programs. Each state will be reviewed once every three years, in a cycle that is expected to take approximately 27 months, to finalize findings and error rates. Texas is scheduled for review in 2008. States must return the federal share of overpayments based on medical and processing errors.

Rules Affecting Funding

HHSC is tracking several new rules from CMS that would significantly shift costs from the federal government to Texas. Chapter V of this document discusses these new rules in the Challenge/Opportunity that is titled "Accessing Federal Funds for Medicaid and Coordination with CMS."

Food Stamp Reauthorization

Public Law 110-234, enacted on May 22, 2008, reauthorized the Food Stamp program through federal fiscal year 2012. The bill has also changed the federal name of the program, which is now known as the Supplemental Nutrition Assistance Program. More information about this program may be found in Chapter V, regarding HHSC.

Chapter IV

Health and Human Services System Ongoing State Planning Requirements and Initiatives

This chapter concludes the overview and external/internal assessment for the Health and Human Services (HHS) System, or Enterprise. The chapter describes ongoing planning efforts of the HHS System agencies, beginning with the Coordinated Strategic Plan (CSP) for Health and Human Services.

Each of the agencies in the HHS Enterprise has other planning responsibilities that are described in the following sections. Some of the planning efforts, such as the HHS Enterprise workforce plan, are the responsibility of all Enterprise agencies, while others, such as the Texas Promoting Independence Plan, involve a subset of Enterprise agencies.

The five chapters that follow focus on the individual agencies in the HHS System, beginning with the Health and Human Services Commission (HHSC). Those chapters discuss each agency's challenges and opportunities, current activities by goal, and internal assessment.

Coordinated Strategic Plan for Health and Human Services

The CSP serves as the Strategic Plan for the HHS System. The CSP requirement preceded House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, and it required the legacy health and human services agencies to produce a single plan addressing challenges and opportunities that these agencies shared. The CSP was completed after each agency had prepared its individual agency Strategic Plan.

Since the enactment of H.B. 2292 and the consolidation of the 12 legacy agencies into the 5 current agencies in a single HHS System, both the CSP and the HHS System agencies' Strategic Plans have been included in this single document. Chapters II through IV of this document constitute the CSP required by Section

531.022 of the Texas Government Code. Since all of the Enterprise agencies have contributed to this Plan, HHSC is using its authority to consolidate reports (granted at Texas Government Code, Section 531.014) to satisfy the CSP requirement.

This Plan meets the requirements for public comment for the CSP and will be provided to all the required recipients for the CSP in July, prior to the CSP due date of October 1, 2008.

Long-Term Care Plan

The Texas Health and Safety Code Section 533.062, requires the submission of a biennial plan, *The Long-Term Care Plan for Persons with Mental Retardation and Related Conditions*, to HHSC no later than July 1 of each even-numbered year. On September 1, 2004, the Department of Aging and Disability Services (DADS) assumed responsibility for this plan and all associated long-term services and support programs for persons with mental retardation. These services and supports include:

- Intermediate Care Facilities for Persons with Mental Retardation Program (ICFs/MR);
- Home and Community-Based Services (HCS) Waiver Program;
- Texas Home Living Waiver Program;
- Community Living Assistance and Support Services Program;
- Deaf-Blind with Multiple Disabilities Waiver Program; and
- Consolidated Waiver Program.

Under this statutory planning requirement, the proposed plan must specify both the capacity of the HCS Waiver Program for persons with mental retardation and the number and levels of new ICF/MR beds to be authorized in each region of the state. After legislative action on the appropriations for long-term services and supports for persons with mental retardation or related conditions, HHSC adjusts the plan to ensure that ICF/MR and HCS capacities are within appropriated amounts. Upon final approval of the plan, HHSC publishes it in the Texas Register.

Texas Promoting Independence Plan

The Texas Promoting Independence Initiative was begun in direct response to the United States Supreme Court decision in *Olmstead vs. L.C.* (June 1999) and Governor George W. Bush's Executive Order GWB 99-2. The purpose of the Initiative is to promote an individual's choice to live in the most integrated residential

setting to receive appropriate long-term services and supports. While this is an HHSC initiative, HHSC has delegated daily management of the Initiative to DADS, through HHS System Circular-002: The Promoting Independence Initiative and Plan.

Executive Order GWB 99-2 required that a report be submitted to the Governor's Office by January 2001, making recommendations regarding services for individuals with disabilities. HHSC established a statewide advisory committee to guide the development of this report, named the Texas Promoting Independence Plan.

The Texas Promoting Independence Plan provided a historical perspective on long-term services and supports in the state of Texas, and it made numerous recommendations for system improvements across the HHS Enterprise. Recommendations for each of the Enterprise agencies were made separately, and collective recommendations were made for the HHS System.

Many of the components of GWB 99-2 and the Plan were codified by Senate Bill (S.B.) 367, 77th Legislature, Regular Session, 2001. This bill required the permanent establishment of a statewide advisory committee, which is known as the Promoting Independence Advisory Committee, and the submittal of a revised Texas Promoting Independence Plan to the Legislature every two years, in the December prior to a legislative session. In addition, S.B. 367 required that the committee submit an annual stakeholder report to the HHSC Executive Commissioner at the beginning of each fiscal year (FY). The annual stakeholder report provides input on the committee's policy concerns and a status report on the progress made by each of the HHS Enterprise agencies.

In April 2002, Governor Rick Perry issued Executive Order RP-13, which further reinforced the new initiative and stated that both the Texas Department of Housing and Community Affairs and the Texas Workforce Commission (TWC) would cooperate to support the initiative and have staff participate on the committee.

The latest plan is the *2006 Revised Texas Promoting Independence Plan (2007)*. A new Plan will be submitted in December 2008, prior to the 81st Legislative Session.

The committee is currently monitoring more than 24 recommendations for changes across the HHS Enterprise. The committee meets quarterly to promote community-based programs for individuals who are older and/or have disabilities, and to provide a discussion platform for current Enterprise-wide issues that may be a barrier to an individual's choice to live in the most integrated setting desired.

Family-Based Alternatives Project

This project was established by S.B. 368, 77th Legislature, Regular Session, 2001, to create family-based alternatives to institutional care for children with disabilities.

Administered by HHSC, the project assists institutionalized children in returning home to their birth families with support. When return home is not possible, the project recruits alternative families, called Support Families, who are carefully matched with children and their birth families to care for children long-term. The project is designed based on research on leading practices around the country.

Through outreach, networking, and training, provider interest in offering family-based alternatives has grown. Through development of informational materials, training, and collaboration, the project has contributed to increased understanding of permanency planning for children traditionally placed in institutions. Since the program began, the number of children with developmental disabilities living in large institutions has declined, while placement of children from institutions into families and family-based alternatives has grown.

Border Regions Initiatives

In the late 1990s, Texas lawmakers became concerned about the need for enhanced services in some Texas border regions, designated by law.[1] Figure 4.1 illustrates these designated regions.

The populations of both the Texas-Louisiana and the Texas-Mexico border regions are growing. From 2009 to the year 2013, the population in the 43 counties comprising the Texas-Mexico border region is expected to grow at a rate slightly lower than the state's population as a whole (7 percent versus 8 percent). The rate of population growth in the 18 counties in the Texas-Louisiana border region is projected to grow at a considerably lower rate (3 percent) compared to the Texas-Mexico border counties. More than 60 counties in these two border areas are geographically isolated and economically distressed.

[1] The Texas-Louisiana Border Region is defined as the area consisting of the counties of Bowie, Camp, Cass, Delta, Franklin, Gregg, Harrison, Hopkins, Lamar, Marion, Morris, Panola, Red River, Rusk, Smith, Titus, Upshur, and Wood. The Texas-Mexico Border Region means the area consisting of the counties of Atascosa, Bandera, Bexar, Brewster, Brooks, Cameron, Crockett, Culberson, Dimmit, Duval, Edwards, El Paso, Frio, Hidalgo, Hudspeth, Jeff Davis, Jim Hogg, Jim Wells, Kenedy, Kerr, Kimble, Kinney, Kleberg, La Salle, Live Oak, Maverick, McMullen, Medina, Nueces, Pecos, Presidio, Real, Reeves, San Patricio, Starr, Sutton, Terrell, Uvalde, Val Verde, Webb, Willacy, Zapata, and Zavala.

Figure 4.1
Designated Border Regions
(According to Senate Bill 501, 76th Legislature, Regular Session, 1999)

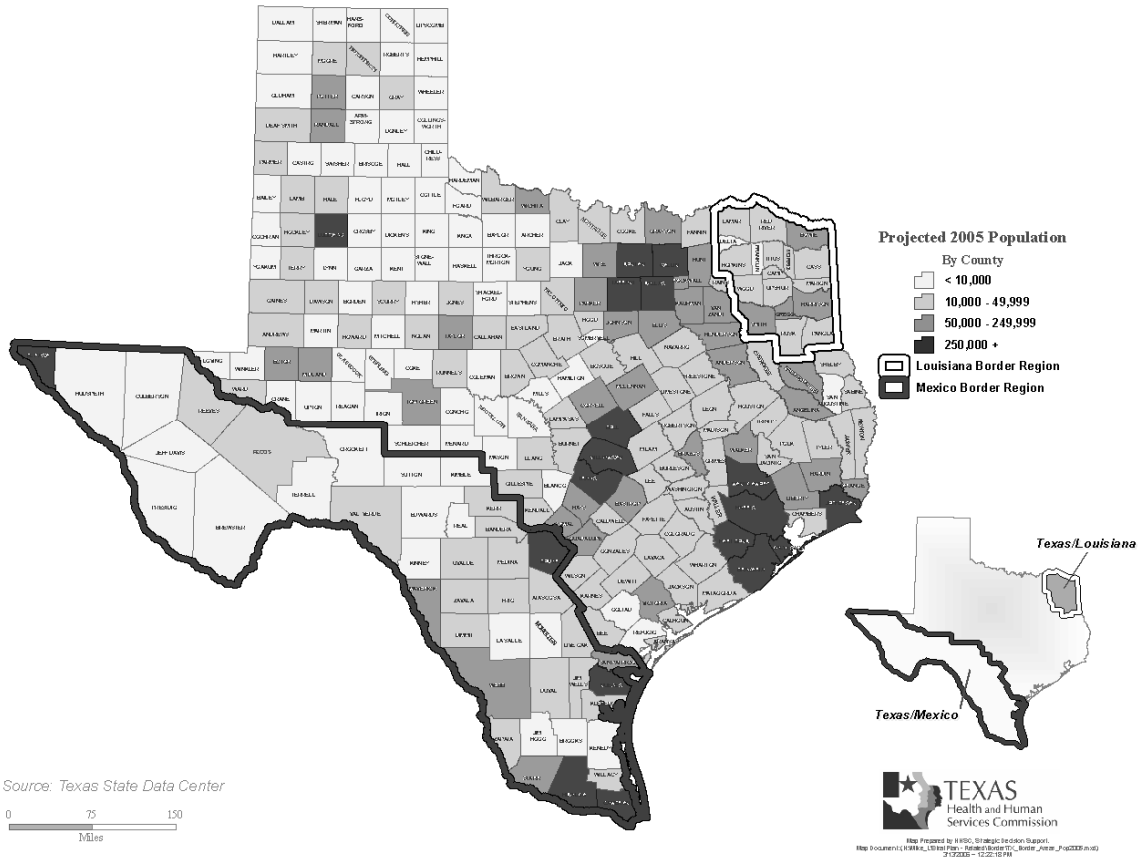


Figure 4.1: HHSC Strategic Decision Support, 2006.

Texas-Mexico Border Region

The Texas-Mexico border extends approximately 1,250 miles along the Rio Grande River, from Ciudad Juarez/El Paso to Matamoros/Brownsville. It is projected that in 2009 the population of this region will represent approximately 20 percent of Texas' total population. Spanish is spoken in more than three-quarters of this region's households. The estimated poverty rate for this region in 2005 is 27 percent, which is considerably higher than the estimated rate of 18 percent for the state as a whole. High levels of poverty in a population or region generally result in a higher demand for health and human services.

More than 500,000 residents of the Texas-Mexico border live in Colonias, generally described as rural, isolated, unincorporated communities with insufficient provision of public utilities such as running water, storm drainage, sewers, electricity, and

telephone service. Due to all these factors, access to health services is also a challenge. More than 2,000 Colonias exist in this area today.

The HHS Enterprise agencies have developed an interagency partnership with the HHSC Office of Border Affairs, the Texas A&M University Colonias Program, the TWC, local workforce development boards, the Texas Education Agency (TEA), local school districts, and educational service centers. The partnership, which has expanded to include numerous community-based organizations and promotora organizations, continues to implement the Texas-Mexico Border Colonias Initiative, a coordinated outreach effort to enhance conditions supporting good health and self-sufficiency in these areas. The interagency consortium seeks ways to provide Colonias residents with better access to state-funded programs. Colonias Initiative Regional Interagency Workgroups actively guide and direct the development of Coordinated Interagency Service Plans. These workgroups are coordinated by HHSC Border Affairs staff in El Paso, Del Rio\Eagle Pass, Laredo, and the Rio Grande Valley. Additionally, each region includes HHS System promotoras, who are community health workers contracted through the Texas A&M Colonias Program.

Texas-Louisiana Border Region

On the Texas-Louisiana border, 18 counties are designated by law for enhancement of service-delivery. Together, the counties encompass 11,448 square miles, including most of the area in the HHS System region known as Upper East Texas. It is projected that in 2009 the population of this region will represent approximately 3.4 percent of the total Texas population. The largest ethnic minority group in this region is African American, projected to represent 18 percent of the total population in the region in 2009. The 2005 poverty rate for this region is estimated at 18 percent, which is also the poverty rate for the state as a whole.

Coordinated Strategy for Early Childhood Services

S.B. 665, 77th Legislature, Regular Session, 2001, required HHSC to create an Office of Early Childhood Coordination (OECC) to coordinate services for children younger than six years of age. The effort involves HHS System agencies and other entities, including TEA, TWC, the Office of Attorney General, and Head Start/Early Head Start programs. The goal of this work is to ensure that upon their entry into school, all children are prepared to succeed. Related legislation, S.B. 54, 77th Legislature, Regular Session, 2001, was enacted that same year, requiring HHSC to deliver a biennial report on HHS System efforts to serve children younger than six years of age. The legislation also authorizes HHSC to provide recommendations to coordinate state agency programs and to propose joint agency collaborative programs related to children younger than six years of age.

In collaboration agencies from within and without the HHS System, the OECC prepared an Early Childhood Comprehensive Systems Plan to increase coordination among existing health and human services and educational services that impact children younger than six years of age and their families. The plan encompasses five components critical to a comprehensive early childhood system:

- Access to health insurance and medical homes,
- Family support,
- Parent education,
- Social-emotional development and mental health, and
- Early care and education.

The Early Childhood Comprehensive Systems Plan also includes strategies to address immunizations.

The plan builds on existing systems and identifies platforms within these systems to help in bridging service gaps, so all children reach school healthy and ready to learn. This is a multi-year initiative with strategies for implementation that began in FY 2007.

Texas Workforce Development System Strategic Planning

The Texas Workforce Investment Council is required by Texas Government Code Section 2308 to develop the Texas workforce by facilitating the seamless delivery of integrated workforce services in Texas. The council is required to develop a strategic plan that establishes the framework for budgeting and operating a workforce development system administered by agencies represented on the council. This plan must include two types of performance measures: formal measures, identifying outcomes that are essentially consistent across all workforce programs, and less formal measures, that provide information determined by the council to be essential in developing the workforce system plan. HHSC and the Department of Assistive and Rehabilitative Services (DARS) participate in this planning process. Their involvement is recorded in Appendix H, in accordance with instructions from the Legislative Budget Board (LBB) and the Governor's Office of Budget, Policy, and Planning (GOBPP).

The 2007 State Strategic Plan for Information Resources Management: *The Texas Transformation*

In accordance with instructions from the LBB and the GOBPP, the requirement for a separate Information Resources Strategic Plan has been eliminated. Agencies must align their technology initiatives to their objectives and State Strategic Plan strategies, and they must include information resources strategic planning in their Strategic Plans.

The 2007 State Strategic Plan for Information Resources Management (*The Texas Transformation)* provides a roadmap that ultimately enables agencies to plan and deploy innovative technologies that will deliver world-class services to Texans. Nine planning elements comprise that roadmap.

Appendix E includes both the health and human services agencies' responses to those nine questions and the Technology Initiative Alignment specified in the LBB and GOBPP instructions. This Appendix constitutes the HHS System's Information Resources Strategic Plan.

Health and Human Services System Workforce Plan for Human Capital Management

The Health and Human Services System Workforce Plan for Human Capital Management for the planning period 2009-13 examines the current status of the HHS System workforce, projects future staffing needs, and addresses strategies to support successful recruitment and retention. This Plan is included as Appendix F.

Planning for and Preparing for Health and Medical Emergencies

Under the Texas Disaster Act of 1975, the Governor is authorized to lead the coordination of Texas' preparation for and response to disasters and emerging events. The Governor has delegated authority for statewide emergency planning and coordination to the Governor's Division of Emergency Management (GDEM).

Texas Government Code Chapter 421 and Section 418.042 require that the GDEM develop and keep current a comprehensive emergency management plan. Texas' emergency preparedness, mitigation, response, and recovery activities are outlined

in the State of Texas Emergency Management Plan. HHSC is assigned primary responsibility for the Plan's Annex V: Food and Water. The Department of State Health Services (DSHS) holds primary responsibility for both Annex D: Radiological Emergency Management and Annex H: Health and Medical Services. HHS System responsibilities include planning and logistical oversight of medical special needs population evacuation (including organizing and deploying EMS assets) and activities regarding shelter.

Although DSHS has primary responsibility for health and medical response, the scope of an effective response requires that other agencies in the HHS System, as well as related stakeholders, make a continuous commitment to planning and collaboration. Planning for disasters is an ongoing, dynamic process and takes place through coordinated networks of partners at the local, regional, statewide, and national levels.

Historically Underutilized Businesses Plan

The HHS System administers programs to encourage participation by historically underutilized businesses (HUBs) in all HHS System agencies' contracting and subcontracting. The System's HUB programs are designed to enhance the ability of HUBs to compete for HHS System contracts, increase agencies' awareness of such businesses, ensure meaningful HUB participation in the procurement process, and assist HHS System agencies in achieving HUB goals.

Each state agency is required to include in its strategic plan a Historically Underutilized Businesses Plan. The section below describes in its entirety a coordinated HUB Plan that covers the HHS System as a whole.

Goal

The goal of the HHS System HUB Plan is to promote fair and competitive business opportunities that maximize the inclusion of HUB, minority-owned businesses, and women-owned businesses, in the procurement and contracting activities of HHS System agencies.

Objective

The HHS System strives to meet or exceed the state's Annual Procurement Utilization Goals in the procurement categories related to the HHS System's current strategies and programs.

Outcome Measures

In procuring goods and services through contracts, the HHS System, as well as each of its individual agencies, will make a good faith effort to meet or exceed the statewide goals for HUB participation for the contracts that the agency expects to award in a fiscal year. Table 4.1 describes these statewide goals.

In accordance with H.B. 3560, 80th Legislature, Regular Session, 2007, state agencies are required to develop their own HUB goals in accordance with the State's Disparity Study. The Comptroller of Public Accounts (CPA) Office, Statewide HUB Program and oversight agency, has instructed all agencies to use the current HUB utilization goals identified in 34 Texas Administrative Code section 20.13, until further notice.

Table 4.1
HUB Goals by Procurement Categories

PROCUREMENT CATEGORIES	UTILIZATION GOALS
Heavy Construction	11.9%
Building Construction	26.1%
Special Trade Construction	57.2%
Professional Services Contracts	20.0%
Other Services Contracts	33.0%
Commodity Contracts	12.6%

Table 4.1: 2007 Statewide HUB Report, Texas Comptroller of Public Accounts.

The HHS System will collectively use the following outcome measure to gauge progress:

- Total expenditures and the percentage of purchases and subcontracts awarded directly and indirectly to HUBs under the procurement categories.

Individual agencies in the HHS System may track additional outcome measures.

HHS System Strategies

When feasible, the HHS System will consider setting higher goals for its contract opportunities. Factors to consider will include: 1) HUB availability, 2) current HUB usage, 3) geographical location of the project, 4) the contractual scope of work, 5) size of the contract, or 6) other relevant factors not yet identified.

The HHS System agencies will also maintain and implement policies and procedures, in accordance with the HUB rules, to guide the agencies in increasing the use of HUBs through direct contracting and/or subcontracting.

The HHS agencies employ several additional strategies, such as:

- Tracking the number of contracts awarded to certified HUBs as a result of HHSC outreach efforts;
- Obtaining assurances that contractors will make a good-faith effort to subcontract with HUBs and maintain the commitment throughout the contract;
- Using available HUB directories, the Internet, minority or women trade organizations or development centers to solicit bids; and/or
- Maintaining a HUB Office, including a full-time HUB Coordinator and two HUB Administrators at the HHSC headquarters for effective coordination.

Output Measures

The HHS System will collectively use, and individually track, the following output measures to gauge progress:

- The total number of bids received from HUBs;
- The total number of contracts awarded to HUBs;
- The total amount of HUB subcontracting;
- The total amount of HUB Procurement Care expenditures;
- The total number of mentor-protégé agreements;
- The total number of HUBs awarded a contract as a direct result of the HHSC outreach efforts; and
- The total number of HUBs provided assistance in becoming HUB certified.

This additional output measure may be used by specific System agencies:

- Number of outreach initiatives such as HUB forums attended and sponsored.

HUB External Assessment

According to the CPA FY 2007 Statewide HUB Report, the HHS System collectively awarded 21.35 percent of all contract funds to HUB contractors. The Department of

Family and Protective Services (DFPS) led the System's agencies by awarding 29.8 percent of its contract funds to HUBs, followed by HHSC, which awarded 25.9 percent of its contract funds to HUBs. Table 4.2 specifies details of these expenditures.

Table 4.2
HHS System Expenditures with Historically Underutilized Businesses, FY 2007, by Agency

Agency	Total Expenditures	Total Spent with All Certified HUBs	Percent
HHSC	$542,183,999	$140,431,945	25.90%
DADS	111,042,058	15,061,665	13.56%
DARS	22,053,058	5,149,593	23.35%
DFPS	49,613,993	14,805,367	29.84%
DSHS	257,833,782	34,408,936	13.35%
Total	$982,726,890	$209,857,506	21.35%

Table 4.2: 2007 Statewide HUB Report, Texas Comptroller of Public Accounts.

The HHS System agencies made a number of internal improvements to help meet statewide HUB goals. HHSC initiated an aggressive outreach effort to educate HUBs and minority businesses about the procurement process. In addition, HHSC coordinates initiatives to help implement the HUB program throughout the HHS System.

Other areas of progress include:

- Promoting HUB usage within agencies' procurement card programs;
- Signing a Memorandum of Cooperation between HHSC and two entities: the Texas Association of African-American Chambers of Commerce, and the Texas Association of Mexican-American Chambers of Commerce;
- Conducting post-award meetings with contractors to discuss the requirements related to the HUB Subcontracting Plan and monthly reporting;
- Advertising HHSC contract opportunities; and
- Developing an HHSC Business Opportunities Page on its website to maintain awareness for all HUBs.

Finally, additional staff resources will be necessary throughout the HHS System to assist with the following functions:

- Enhancing outreach efforts internally and externally by promoting access, awareness, and accountability through education and training;
- Enhancing minority- and woman-owned businesses' participation in System-sponsored HUB Forums where exhibitors may participate in trade-related conferences;
- Enhancing HHS System HUB reporting capabilities;
- Expanding HHS System mentor-protégé program vision to maximize the state's resources through cooperation and assistance from other public entities and corporate businesses; and,
- Promoting and increasing awareness of subcontracting opportunities in HHS System contracts, which are identified in contractors' HUB Subcontracting Plans.

Chapter V

Health and Human Services Commission External/Internal Assessment

The Health and Human Services Commission (HHSC) was created in 1991 by the 72nd Legislature to provide the leadership and innovation necessary to administer an efficient and effective Health and Human Services (HHS) System for Texas. The responsibilities of HHSC have grown substantially since its inception, particularly since the enactment of House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003. Under H.B. 2292, HHSC was given enhanced oversight responsibility over a consolidated HHS System, which includes four other agencies:

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

HHSC was also given responsibility for the provision of centralized support services for all agencies in the HHS System and was given major direct operational responsibilities in such areas as eligibility determination.

The material in this chapter is arranged as follows:

- Challenges and Opportunities;
- Current Activities by Goal:
  - Target Populations,
  - Service Descriptions, and
  - Trends and Initiatives; and
- Internal Assessment.

Challenges and Opportunities

In providing leadership and oversight of the HHS Enterprise and in administering its own programs and operations, HHSC remains focused on the broad vision of a

transformed system of health and human services. Achievement of that vision is guided by three themes:

- A focus on clients and program delivery;
- Effective stewardship of public resources; and
- Cultural change and accountability.

The following sections discuss some of the major opportunities and challenges that will be the focus of ongoing improvement and optimization efforts at HHSC during the next few years.

Medicaid/CHIP

Medicaid and the Children's Health Insurance Program (CHIP) comprise the majority of appropriations to HHSC. In August 2007, approximately 2.9 million Texans of all ages were enrolled in Medicaid, and approximately 300,262 children younger than 19 years of age were enrolled in CHIP. For the 2008-09 biennium, Medicaid and CHIP programs were appropriated a total of $29.1 billion in all funds, representing approximately 93 percent of the total HHSC appropriation of $31.3 billion.

Under federal provisions and requirements for Medicaid and CHIP, Texas establishes its own eligibility standards, determines the extent of services, sets payment rates, and administers its own programs.

Increasing Caseloads

Medicaid covers acute health care such as services from the following: physicians, inpatient and outpatient hospitals, pharmacies, laboratories, and X-ray services locations. Medicaid acute care caseloads have increased every year since fiscal year (FY) 2000, and are projected to continue increasing in the 2008-09 biennium. From FY 2000 to FY 2007, the caseload increased by more than one million clients, an increase of approximately 55 percent.

In particular, the caseloads for non-disabled, non-Temporary Assistance for Needy Families (TANF) children from birth to 18 years of age increased by almost one million clients (approximately 995,000), and older and disability-related clients increased by close to 150,000. TANF clients in Medicaid declined, and are projected to stabilize, while growth is projected to slowly continue for children, older people, people with disabilities, and pregnant clients.

CHIP caseloads are projected to increase in the next biennium, reaching more than 500,000 clients in FY 2009. This increase is largely due to:

- Restoration of previous eligibility standards such as 12 months' continuous eligibility, and
- The perinatal program, covering infants younger than 12 months, who would otherwise have been in Medicaid.

Eligibility system channels are now open to allow consumers to obtain information and apply for Medicaid, CHIP, Food Stamps, and TANF benefits in person, over the phone, by mail, by facsimile (Fax), and via the Internet. Increased access will contribute to increases in applications, in eligibility determination processing, and in caseloads.

Increasing Utilization and Costs

Utilization is the term used to refer to the extent to which clients use a program or service during a given time period. Utilization is impacted by changes in caseload size, use per client, and the mix of clients, since different client groups have different patterns of use. Utilization is also impacted by changing patterns of use caused by new technologies.

The relationship between utilization and costs can be complex. For instance, increased utilization due to large increases in caseloads among groups that are low-cost with low utilization per case (older children) may result in little cost growth. On the other hand, increased utilization due to small increases in high-cost, high-needs clients can result in significant cost growth.

Another area impacting utilization, and thus costs, is increased participation in managed care, which adds further complexity to the cost/utilization mix. Clients whose care is managed may have increased utilization, and that utilization may be aimed at preventative care and early intervention, avoiding more costly care such as hospitalizations. HHSC is analyzing claims data and encounter reports, to track changes and patterns in utilization and to determine how the changes in client mix and service delivery will impact future costs.

Health Care and Medicaid Reform

The health care system in Texas is facing significant challenges. The state's health care costs are increasing, its rate of uninsured is the highest in the nation, and its insurance premiums are costly and often out of reach for individuals and small business owners. The current health care system relies heavily on public hospital settings as the main place where the uninsured get care. Despite billions of dollars being spent to provide care for the uninsured, it is still hard for people without insurance to see a physician for basic primary care or preventive care.

In addition, proposed federal changes place hundreds of millions of dollars in funding for hospital payments at risk. These proposed changes in hospital payments will likely mean that Texas public hospitals and the local communities whose taxes support them will be faced with a loss of almost $500 million per year in federal Medicaid funding.

The Texas Legislature enacted Senate Bill (S.B.) 10, 80th Legislature, Regular Session, 2007 to improve health care in Texas, help support public hospitals, and provide funding and direction for HHSC to work with the federal government to improve access to care in Texas. One initiative includes new funding to help pay for insurance coverage for some Texans who do not have health insurance.

The goals of health care reform based on S.B. 10 are to:

- Develop a more efficient and cost-effective system to provide care for uninsured individuals by emphasizing care management, primary care, and prevention with a non-entitlement, non-traditional Medicaid-funded subsidy;
- Promote access, affordability, and choice in extending health insurance and coverage to more uninsured Texans;
- Protect and support the stability of the health care safety net infrastructure;
- Protect at-risk federal funding of nearly $500 million in funds used to pay to Texas health care providers;
- Maximize federal funds for health care services to the uninsured, costs now funded solely with state and local public funding;
- Build on existing strengths of public-private partnerships, including employer-sponsored insurance, individual and small group market insurance, and other Texas programs, including the state's high risk pool and other coverage;
- Increase personal responsibility by providing incentives to improve health care outcomes; and
- Help support a culture of insurance as part of the health care system transformation.

S.B. 10 mandated creation of a Health Opportunity Pool, a fund that can be used both to maintain current funding to hospital programs for providing services to individuals who are uninsured, and to provide funding to pay for insurance coverage for some of the Texans who are currently uninsured. Because federal funds will be used in these programs, HHSC must reach an agreement with the federal agency that oversees Medicaid, the Centers for Medicare and Medicaid Services (CMS), to implement these programs.

Medicaid Benefits Process

HHSC is developing improvements to the Medicaid benefits review process, through which HHSC reviews existing medical policies and develops medical policies associated with new Medicaid acute care benefits. Through this process, HHSC must evaluate whether to add or modify Medicaid benefits. This process is especially important, given the ongoing changes in health care services and products, technology, consumer needs, the business world, and the political environment.

One feature of the revised process will be the establishment of performance metrics for each step of the review process. These metrics will be used to monitor and measure implementation effectiveness. Monthly reports regarding the status of medical policies will be produced for management reporting and oversight. HHSC will also integrate a dedicated fiscal team into the benefit review process to perform pricing research and fiscal impact analysis, and to review all Medicaid fees on a biennial basis. HHSC anticipates that improvements to the benefit review process during 2008 will reduce the amount of time needed to make a Medicaid acute care benefit available to Medicaid beneficiaries while ensuring consistency in the development of medical policy.

Accessing Federal Funds for Medicaid and Coordination with CMS

CMS has adopted or proposed several rules that will shift billions of dollars in Medicaid costs from the federal government to states, local governments, and school districts. These recent actions are a departure from past practices and will place a significant new fiscal burden on states. At the same time, the new rules will limit the ability of states to maintain flexibility and authority over their own programs. Texas will lose federal funding for several services and will experience reduced or eliminated reimbursement for a number of providers. HHSC has concerns about several CMS regulatory actions.

- **Government Provider Cost Limit Regulation—**This regulation imposes new restrictions on payments to government providers, such as public hospitals.
- **School-Based Medicaid Services – Administration and Transportation—** Medicaid covers school-based health services, including physician and nursing services, personal care services and various therapies, for certain children. However, CMS will eliminate funding for school-based administration and transportation activities.
- **Rehabilitation Services—**The rehabilitation services rule will no longer allow reimbursement for a number of currently reimbursable Medicaid rehabilitative services.
- **Case Management—**CMS will eliminate federal funding for certain case management programs and will require the restructuring of other case management programs.

Texas also has numerous State Plan Amendments (SPAs) pending because they are in question with CMS. States must submit a SPA when they make changes to their Medicaid programs, including changes in reimbursement for services. CMS is applying a new level of scrutiny and reversing its previous decisions on a number of these SPAs. CMS has intimated that they could withhold federal matching funds for any SPAs that are pending. This could result in hundreds of millions of dollars being withheld from the state, as CMS deliberates on the SPAs that Texas has submitted.

Re-Procurement of the Claims Administrator Contracts

HHSC contracts with a claims administrator vendor to perform complex tasks vital to Medicaid operations. In addition to processing claims for traditional fee-for-service Medicaid, Children with Special Health Care Needs (CSHCN) Services Program, and Primary Care Case Management (PCCM), the claims administrator administers the PCCM program, enrolls Medicaid providers, performs outreach and education to Medicaid providers, provides customer service, and implements other necessary functions of the Medicaid program. The claims administrator contractor processes approximately one million claims per week, disburses approximately $120 million each week in payments to providers, and supports more than 40,000 providers statewide.

HHSC is integrating the re-procurement of the service Pharmacy Claims and Rebate Administration (PCRA) with the re-procurement of the claims administrator. The PCRA contractor is responsible for processing pharmacy claims and managing pharmacy rebates. The PCRA contractor pays more than a half million claims and disburses almost $34 million each week to pharmacies. Integrating these procurements creates the opportunity for one vendor to provide both sets of functions, to streamline contract oversight and management.

The scope of the contract will be very large in terms of duties performed and the dollar value of the contract. The re-procurement of the claims administrator and PCRA contracts will be managed by the Medicaid/CHIP Procurement and Contract Management Unit and will follow the performance-based procurement model. All procurement-related activities will be conducted at an off-site location to assure project integrity.

As a result of the procurement, HHSC may acquire a new claims processing system or receive a proposal for re-engineering the existing claims processing system. HHSC will work with its vendors to address implementation challenges, including ensuring consistent operation during the contract transition and system changes. Because the request for proposals for this re-procurement includes updated requirements that more clearly define expectations and establish clear performance metrics, HHSC anticipates improved operations under the new contract.

Medicaid Access Card Project

HHSC is developing a new Medicaid Access Card (MAC) system that will replace the current paper Medicaid identification forms mailed to clients each month. The MAC system, using plastic identification cards to authenticate clients at the point of service, was piloted in six Texas counties beginning in 2004. Based on the success of that pilot, HHSC will implement the MAC system statewide.

HHSC anticipates having the MAC system in place by the end of 2009. The system components include a small point-of-service device, similar to a credit card authorization device. The system will be provided at no cost to providers or clients.

The cards are anticipated to provide significant improvements for all people involved in the Medicaid program, by improving client access, enhancing processing for providers, and saving time for providers and clients. The new system offers several major benefits.

- **Express Client Check-In**—The client check-in process will be faster than the current manual process.
- **Quick Medicaid Eligibility Verification**—Automated eligibility verification provides a quick validation of current Medicaid eligibility status.
- **Electronic Health Record**—An electronic health record feature will provide MAC transaction history and will access data from the Medicaid claims systems.
- **Pro-active Program Notifications—**Automated notifications regarding needed Texas Health Steps (THSteps) check-ups and other program information will be sent to providers and clients to encourage timely access to services.
- **User Portals –** Clients, providers, and program support staff will have access to client health information via user portals.

Frew v. Hawkins

In 1993, a class action lawsuit, commonly known as *Frew v. Hawkins*, was filed against the State on behalf of more than 1.5 million Medicaid enrolled children. The suit alleged that Texas did not adequately provide Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

The federal court found the state in violation of the terms of the consent decree and ordered corrective action. After the state exhausted all avenues for appeal, a hearing for corrective action was scheduled for April 2007. Prior to this hearing, the parties negotiated an agreed set of corrective actions.

Several corrective action plans and strategic initiatives are being implemented to meet the requirements of *Frew v. Hawkins*. In accordance with federal law and the *Frew* court order, HHSC must offer health and developmental assessments and vision, dental, and hearing services to Medicaid recipients younger than 21 years of age, including diagnostic and treatment services necessary to correct or ameliorate physical and mental illnesses and conditions. These services are covered benefits under the Social Security Act and referred to as the EPSDT service at the federal level and as the THSteps program in Texas.

H.B. 15, 80th Legislature, Regular Session, 2007 appropriated approximately $1.8 billion for the 2008-09 biennium, to support the state's responsibilities and efforts in response to the judicially-approved agreed corrective action plans. H.B. 15 required the development and submission of a plan to the Governor and the Legislative Budget Board (LBB), detailing the proposed *Frew* expenditures. HHSC submitted

the H.B. 15 *Frew* Expenditure Plan September 1, 2007. The H.B. 15 plan provides for funding of the following during the 2008-09 biennium:

- $1.3 billion allocated for immediate increases in Medicaid reimbursement to providers for services to persons younger than 21 years of age, as an incentive for physicians and dentists to open their practices to new THSteps clients;
- $91.6 million for implementation of the 11 Corrective Action Plans (CAPs) to address outstanding issues in the Consent Decree; and
- $150 million from general revenue to finance various strategic medical and dental initiatives relating to health care services provided to children enrolled in Medicaid.

HHSC has instituted physician and dentist reimbursement rate increases effective September 1, 2007, has begun implementation of the CAPs, and has engaged stakeholders regarding more than 30 proposed strategic initiatives.

Before HHSC implements strategic initiatives to improve access to care and providers for children younger than 21 years of age, the agency requests formal expenditure authority approval from the LBB and the Governor.

Beyond the current biennium, analysis of the appropriateness of provider rates will be needed. HHSC will need to determine the impact of the provider rate increases on actual client utilization of services and the additional number of providers actively involved in providing critical services to children enrolled in Medicaid. HHSC will consider these variables in determining the impact of rate increases to improving access to health care services and providers in Medicaid for children younger than 21 years of age.

Medical Transportation Program

The Medical Transportation Program (MTP) arranges non-emergency transportation for:

- Certain eligible Medicaid recipients;
- CSHCN Services Program clients; and
- Clients eligible for the Transportation for the Indigent Cancer Patient program who do not have any other means of transportation to access medically necessary, allowable services.

S.B.10 transferred the administration and operation of the MTP from the Texas Department of Transportation (TxDOT) to HHSC. The transition was effective at the end of April 2008. Many of the staff will not be physically moved into HHSC space until after the beginning of FY 2009.

In FY 2007, MTP provided slightly more than 4.2 million one-way trips, as a result of nearly 2.5 million calls. For FY 2008, the program is expected to provide more than 5.1 million trips, based on nearly 2.9 million calls.

The program has undergone significant changes in the last few years. In 2004, the program was transferred to TxDOT, and while there, the program consolidated call centers, made changes in contracting, and began to address the *Frew* settlement requirements.

As a part of the transition to HHSC, a review of the call center technology revealed opportunities to increase client access and to improve call center operations. These improvements were incorporated into the transition plan.

There are still many challenges to be addressed following the transition, including:

- Escalating cost of transportation services due to the increased number of trips and increased cost of fuel;
- Increase in call volumes;
- Ongoing compliance with *Frew* requirements; and
- Compliance with federal and state rules and regulations.

Following the transition, HHSC will conduct a thorough business process review in order to improve client services and program operations.

Hospital Medicaid Financing

The Texas system for reimbursing hospitals for treating Medicaid clients is outdated. Accordingly, in the next few years there will be major changes to hospital financing methods. To help avoid major financial disruptions to hospitals, the Legislature appropriated an additional $150 million in General Revenue for the 2008-09 biennium, which will draw $229 million in federal matching funds, for a total of approximately $379 million.

A new reimbursement system will be developed that more appropriately reflects the actual cost of care and will involve restructuring how Texas pays for each of the thousands of different procedures and expenses necessary for medical care in a hospital setting. HHSC will also look for new approaches to helping those hospitals that bear the burden of caring for most of the uninsured. Some hospitals will see their rates increased earlier (e.g., psychiatric hospitals and state teaching hospitals). For other hospitals, payment rate increases will be phased in.

Payment Error Rate Measurement

The federal CMS created the Payment Error Rate Measurement (PERM) program to determine the extent of error rates across the country in Medicaid and CHIP eligibility determinations and claims payments for fee-for service and managed care

services. Each state is to be reviewed once every three years, and Texas is being reviewed for the first time in FY 2008.

Coordination of PERM program implementation within the HHS System, including acting as the single point of contact with CMS on PERM issues, has been assigned to HHSC Internal Audit. The Office of Family Services has been assigned to perform PERM eligibility reviews and began performing these reviews in February, 2008. CMS contractors will perform medical claims reviews, and will begin performing these reviews during 2008. All agencies in the HHS Enterprise will be involved in the appeal and resolution of claims errors identified by CMS contractors, and in the development and implementation of corrective actions designed to reduce overpayments and other related errors in the future.

In a proactive effort to minimize Texas' error rate, HHSC is communicating with medical providers and other stakeholders regarding PERM requirements. A primary goal of these communications, prior to the initiation of claims reviews, is to increase awareness in the provider community that Medicaid and CHIP medical records may be requested by CMS contractors. Providers are asked to update their contact information filed with HHSC, and they are being informed that failure to submit requested medical records to the CMS contractors will result in error findings.

Providers will be required to reimburse HHSC for any amounts associated with overpayments identified through the PERM reviews, and HHSC will be required to return to CMS the federal share associated with each overpayment.

Strengthening Fraud Recovery Opportunities in Medicaid/CHIP

The Office of Inspector General (OIG) has observed that in some Medicaid or CHIP cases in which elements of fraud have been identified, the cases are not deemed appropriate for criminal prosecution. Unlike TANF and food stamp cases, no process is currently in place to address recovery opportunities in cases deemed inappropriate for criminal prosecution. Accordingly, in these cases the opportunity is lost for recovery of funds paid out under fraudulent circumstances.

A recovery process of administrative hearings may be appropriate, to provide an additional avenue by which to establish proof of an intentional program violation in these Medicaid and CHIP cases, and thus to recover overpaid benefits. Referral of Food Stamp and TANF cases for an administrative hearing is specified by rule in the Texas Administrative Code. Neither Medicaid nor CHIP is mentioned in the rule. In a related section regarding CHIP responsibilities, the applicant is responsible for reimbursement of improperly paid benefits. The possibility of prosecution is also mentioned in this rule, but not any other means of establishing the impropriety of the benefits. Specific administrative authority to bring consistent fraud recovery opportunities to all these programs would potentially increase recoveries of overpaid benefits.

Federal State Children's Health Insurance Program Reauthorization

In December 2007 Congress passed the "Medicare, Medicaid and SCHIP Extension Act of 2007," which extends funding for the State Children's Health Insurance Program (SCHIP) program until March 31, 2009. Several challenges and opportunities could arise when Congress resumes negotiations over a full SCHIP reauthorization bill, depending on the direction and scope of reauthorization legislation. In 2008, the Texas CHIP program is operating with an estimated budget surplus of $776 million. Under the current funding scenario, Texas does not expect to experience a budget shortfall in the CHIP program until 2012. However, Texas' CHIP population is expanding as a result of H.B. 109, 80th Texas Legislature, Regular Session, 2007, and the CHIP Perinatal Program; thus, it is unknown whether future federal funding will continue to support the Texas CHIP population.

HHSC will closely monitor Congressional developments in 2008 related to SCHIP that may impact the State. In particular, HHSC will track possible changes to the federal funding formula and the three-year spending limit, which determines how long states can retain unspent SCHIP allotments. Texas CHIP may also be impacted if significant changes are made to income disallowance limits or other eligibility criteria.

Improving Access to Children's Health Insurance

HHSC joined the Office of the Attorney General (OAG) and the Texas Department of Insurance in a pilot program funded by the United States Department of Health and Human Services (U.S. DHHS), Office of Child Support Enforcement. This pilot proposes to help more Texas children obtain continuous health care coverage. Awarded in September 2007, the pilot project called Niños Sanos (Healthy Children) will build on the strength of the existing partnership between the OAG and HHSC, the state's Medicaid agency. This project is designed to provide more comprehensive services to children on the child support caseload who qualify for government assistance. The pilot will also ensure that private health insurance information is available for children when it is the appropriate health care solution.

The project funds three medical support specialists who also function as Medicaid eligibility workers. The dual role will result in recommendations for a child's health care coverage that accurately reflect the parents' circumstances. For example, these joint employees will have the expertise to determine eligibility for CHIP and Medicaid, and to enroll eligible children. The specialized staff will track lapses in coverage, to ensure that children receive continuous health care coverage.

The funding for this pilot program lasts three years, during which time its efficacy will be evaluated. Depending on the success of the pilot, certain activities will be explored for statewide expansion.

Enhanced Eligibility System

H.B. 3575, 80th Legislature, Regular Session, 2007, directed HHSC to develop a transition plan under which the eligibility system in existence on September 1, 2007 is transformed and enhanced to be more fully functional relative to the needs of eligible consumers. The transformation of the eligibility system requires significant changes to business processes, to the workforce, and to the technology and automation that supports eligibility determination. The transition plan includes the next steps for the eligibility system and is available on-line at: www.hhs.state.tx.us/consolidation/IE/HB_3575_TransitionPlan.pdf.

Accordingly, HHSC is implementing a major redesign of the system used to determine if people are eligible and qualify for Medicaid, Food Stamps, TANF, and Medicaid for Elderly and Persons with Disabilities (MEPD) programs. The state's goals are to increase access to services, implement efficient and simplified business processes, reduce fraud, and comply with federal law. The objectives of the new eligibility system include:

- Improving client access and convenience;
- Improving integrity and streamlining processing time by collecting the client information, data, and documents needed to certify eligibility in the beginning of the application process;
- Reducing the number of times a client must be contacted to provide "missing information"; and
- Applying business rules in an automated environment.

The new eligibility system has been implemented in Travis, Hays, and Williamson counties in six offices. It provides clients with multiple access channels, including telephone, Internet, mail, fax, and a network of local eligibility offices. As a result, there is no longer a need for clients to be assigned to specific offices and caseworkers. Call centers receive and begin the processing of applications and renewals. While the new eligibility system expands the ways people can apply for services, it does not change the actual service or the standards for eligibility.

Business Process and Workforce

Eligibility determination staff must work in two distinct eligibility systems. They determine eligibility for cases in the current ("old" or "legacy") system and in the developing (new) system. The processes are different, and this change has created operational stresses for clients and staff. High turnover of eligibility determination staff and the concurrent increase in eligibility applications have contributed to increased caseloads, lower tenure, increased training needs, and challenges in meeting state and federal timeliness and accuracy standards.

Technology and Automation Supporting Eligibility Determination

The Texas Integrated Eligibility Redesign System (TIERS) and supporting technologies comprise the automation that enables and supports modernized eligibility determination and managed care enrollment for HHS Enterprise programs. TIERS is used to process and determine eligibility for the programs listed above, manage workflow, store documents, maintain appointment schedules, and support other functions of the office of eligibility services. CHIP will be integrated into TIERS in FY 2009.

The continued development and deployment of TIERS will be carried out over an extended time period and will involve several major steps:

- Conversion of approximately 8 million records;
- Training of approximately 7,100 employees to use the new system; and
- Securing federal approval for TIERS deployment in offices statewide.

As noted earlier, until TIERS can be implemented in all eligibility offices and locations, state eligibility staff must work in two distinct eligibility automation systems, the System for Application, Verification, Eligibility, Referral, and Reporting (SAVERR) and TIERS. Both systems must be staffed, programmed, and maintained. Data from each system must be manually combined for reporting. Other challenges include statewide conversion to TIERS and retirement of the antiquated SAVERR system; integration of eligibility determination for CHIP and MEPD into TIERS; and preparation for the competitive procurement of TIERS maintenance in 2010.

2-1-1 Texas Information and Referral Network

The Texas Information and Referral Network (TIRN) is a comprehensive statewide information and referral network whose mission is to provide all Texans with information about health and human services on the local, regional, state, and national level. When a person dials 2-1-1 on the telephone, a professional information specialist provides referrals to meet the caller's needs. In 2007, through a decentralized system of 25 private partnerships, the TIRN handled more than 1.9 million calls for general information and referral.

A major new opportunity for 2-1-1 TIRN came with the passage of S.B. 1058, 80th Legislature, Regular Session, 2007. This bill required the Adjutant General's Department to develop a referral program for providing information on reintegration services to military service members, their families, and their dependents. The Adjutant General's Office convened the TexVet coalition, a team composed of a variety of state and federal agencies, 2-1-1 TIRN plays a key role in developing a directory of services, resources, tools, and counseling programs available to aid veterans and their immediate families in the reintegration process, and then in

sharing information with and making referrals to service members requesting assistance.

Information and referral services are a crucial part of disaster prevention, preparation, response, and recovery. The *Texas Homeland Security Strategic Plan of 2005-2010* requires TIRN to assume an extensive role in providing disaster and emergency information to the public, including serving as the initial point of contact for the Transportation Assistance Registry, which coordinates efforts to help people with special needs evacuate before a disaster. Through several disasters in past years, 2-1-1 TIRN has met this crucial need—most dramatically during Hurricanes Katrina and Rita, and in locally serious disasters such as flooding and tornados. TIRN has developed an action plan to address disaster needs, and staff improves and adapts the plan based on experience gained during these disaster events.

Evolving Finance Methods

As Medicaid program services and payment systems become increasingly consolidated into managed health care and PCCM, opportunities arise to re-evaluate these programs and existing fee-for-service programs, to determine how to change HHSC budget development strategies to fit these new models. Examples are as follows:

- ***STAR+PLUS***—The STAR+PLUS model continues to be evaluated and redesigned for increased cost-effectiveness. HHSC may elect to expand STAR+PLUS into El Paso and/or Lubbock.
- ***Foster Care***—Health care for children in foster care has in the past been a fee-for-service Medicaid program. In FY 2008, these children will be transitioned into managed care.
- ***Integrated Case Management***—The model is being evaluated in comparison to other models, and it will be adapted as necessary to enhance cost-effectiveness.
- ***PCCM***—The PCCM model is being evaluated for possible revisions that would focus on clients with chronic illnesses, with the goal being to lower costs while maintaining or improving the level of care. HHSC may consider merging this program with the disease management program, as the populations are very similar.
- ***Streamlining Medicaid Processes***—Across the state, there are many different health programs with different finance structures. HHSC is considering possible consolidation and/or restructuring of these programs, to streamline the payment methodologies as appropriate.
- ***MTP***—As the MTP has transitioned to HHSC from TxDOT, HHSC will consider and implement a payment structure that would fit appropriately.

Data Governance

Data governance is a process that addresses ongoing business issues concerning data quality, including the collection, analysis, and reporting of data. HHSC currently lacks a set of processes governing how data are managed, used, and reported, and how priorities are determined for information technology projects. The Executive Commissioner approved the creation of an HHSC Data Governance Steering Committee to address these concerns and to develop solutions. As a subcommittee of the existing Business and Technology, the HHSC Data Governance Steering Committee will meet on an on-going basis to identify issues and to make decisions by consensus. The data governance process will begin by identifying the various data needed to meet HHSC goals. The Steering Committee will also address such topics as:

- Establishing data standards and policies to ensure the integrity, consistency, and security of all shared data assets;
- Ensuring that accurate and consistent information is released by HHSC with agreed-upon and published meanings;
- Establishing a process to evaluate requested data changes;
- Creating an escalation process to resolve conflicts; and
- Prioritizing data needs and data-sharing across HHSC.

Data Warehouse

In contrast to data governance, which is a process of establishing policies, a data warehouse is a critical tool to store a variety of data in a single location. During the 2008-09 biennium, HHSC was allocated $10 million for the development of a data warehouse that will provide the HHS System the tools to accomplish the following purposes:

- Improving delivery of health care services;
- Determining which programs are most effective;
- Detecting fraud and abuse;
- Reducing overall costs to taxpayers; and
- Predicting the state's human services needs and priorities in years to come.

The data warehouse will make possible a consolidated view of diverse data sources currently stored in a variety of formats and locations. Initially, the warehouse will be concentrated on HHSC programs such as Medicaid, CHIP, Food Stamps, and TANF. Later, the warehouse may be expanded to include programs at other agencies in the HHS System.

Integrated Benefits Card

Pursuant to S.B. 46, 79th Legislature, Regular Session, 2005, the Integrated Benefits Card (IBC) Program is being evaluated as a method to consolidate recipient information and benefits issuance. The IBC will involve the use of a single card and a centralized card management system for multiple programs. The IBC will be simpler for consumers and for providers/retailers, with a single card to manage. At the same time, the IBC will reduce operating costs, with a single card management system to be maintained and operated, and the system will support additional programs in the future.

The IBC will leverage existing technology and add programs by level of complexity. The initial incorporation of programs may include:

- Lone Star Electronic Benefits Transfer (EBT) Food Stamps and TANF;
- Medicaid Access Card; and
- Women, Infants and Children EBT.

When implemented, the IBC Program will be carefully planned to coordinate requirements and policies of participating programs and to allocate costs among those programs, and it will also be aligned with other statewide initiatives involving integration of functions and programs.

The IBC Program is unfunded for the 2008-09 biennium; however, preliminary planning activities are continuing. A request for funding for an IBC project in HHSC's Legislative Appropriations Request for the 2010-11 biennium is planned.

Data Sharing for Fair Hearing Reviews

H.B. 75, 80th Legislature, Regular Session, 2007, makes most HHSC fair hearing decisions subject to judicial review. Effective implementation of this legislation requires HHSC attorneys and hearings staff to be able to use shared data, including digitized recordings of fair hearings as well as client records. In addition, HHSC attorneys throughout the state would benefit from a shared database of legal decisions and opinions to ensure consistency and the efficient use of legal resources.

The creation of a shared database will make it possible to meet the timeframes required by H.B. 75 and will ensure that hearing decisions are better coordinated, more accurate, and clearer. The database can also provide HHSC attorneys with a valuable tool in the provision of legal advice and representation for other HHSC staff.

Current Activities by Goal: Target Populations, Service Descriptions, and Trends and Initiatives

HHSC Goal 1: HHS Enterprise Oversight and Policy

HHSC will improve the effectiveness and efficiency of the delivery of health and human services in Texas through the oversight and coordination of a prompt, accurate, and comprehensive service delivery system.

Health and Human Services Oversight and Transition

Since 2004, Texas has achieved a consolidation and streamlining that has created an integrated system of five agencies, from a system of 12 largely independent agencies. HHSC exercises oversight, coordination, and policy-making functions that are critical to the success and functioning of this integrated system. HHSC also provides centralized or coordinated support and administrative services that are key to the efficient and effective functioning of the system. The sections below highlight functions and responsibilities that are oriented to the effective operation of an integrated HHS System.

System Support Services

During the 2007-08 biennium, HHSC assumed responsibility to plan and implement an efficient and effective centralized system of support services for the agencies in the HHS Enterprise. On September 1, 2007, System Support Services was reorganized for greater efficiency and effectiveness. The System Support Services deputyship now includes the following functions, discussed below: 1) Consumer Support and Workforce Services, and 2) Business and Regional Services.

Consumer Support and Workforce Services

The new Consumer Support and Workforce Services associateship was created on September 1, 2007. It is responsible for directing the following functions, discussed below: Human Resources (HR), Civil Rights Office (CRO), Ombudsman, and the newly created Office of Community Collaboration (OCC).

Human Resources

Under H.B. 2292, HHSC assumed responsibility to plan and implement a centralized HHS Enterprise HR (HHS HR) organization to provide consistent policies, practices, and services to employees across the HHS Enterprise. State human resource professionals staff the HHS HR organization, and a privately managed service center provides services related to human resources, payroll, and time and leave.

The implementation of the "accessHR" project provides self-service functionality to HHS Enterprise employees for several human resources processes, including hiring.

The human resources staff will continue to provide HHS System staff with tools and assistance needed to accomplish their mission. In addition to ongoing policy interpretation and guidance and training, an area of particular focus is building on experiences to date to improve the "accessHR" service center and its self-service functionality. Another area of emphasis will be development of strategies to address improvement opportunities identified through the Survey of Organizational Excellence administered in 2007 and a training needs assessment administered in April 2008.

Civil Rights Office

The CRO provides advice and technical assistance to HHS System managers and employees in maintaining a work environment free of discrimination, harassment, and retaliation. The CRO also ensures equal access to services for clients of programs, activities, and services in the HHS System.

The CRO performs six principal functions to support to agencies in the HHS System, including:

- Providing subject matter expertise;
- Investigating and resolving disputes;
- Ensuring compliance with civil rights laws and federal requirements;
- Ensuring accessibility for people with disabilities;
- Providing training; and
- Reporting agency data and trends to HHS System executive management.

The CRO is researching and developing strategies to streamline operations through the use of technology, computer-based training, and teleconferencing. Two focus areas include: 1) processes for compliance reviews, and 2) placing resources closer to the customer base.

The CRO staff actively participates in Enterprise technology initiatives to ensure accessibility for persons with sensory and speech impairments and, additionally, continues to ensure that people with limited English proficiency are able to access services from the HHS Enterprise.

Office of the Ombudsman

Established pursuant to H.B. 2292, the HHS Ombudsman serves as an impartial and confidential resource, assisting the public in resolving complaints and issues. The office of the Ombudsman conducts independent reviews of complaints concerning policies or practices of agencies in the HHS System, if these complaints are not resolvable at the program level. The office of the Ombudsman ensures that

individuals are treated fairly and with dignity, and makes appropriate referrals and recommendations on complaints. The office also performs informal dispute resolution activities for certain long-term care facilities.

The office will continue enhancing communication and coordination in the HHS Enterprise to improve its response to public complaints and inquiries. The office will identify and analyze Enterprise-wide trends in public complaints and inquiries and will work with various program areas to ensure that issues are continuously monitored and effective policies and procedures are implemented to address and resolve issues.

Office of Community Collaboration

S.B. 1188, 79th Legislature, Regular Session, 2005, required HHSC to create an office of community collaboration. The purpose of the office is to share information and foster collaboration with stakeholders to improve elements of local health care systems.

The HHSC OCC was established in September 2007. This office is responsible for collaborating with community, state, and federal stakeholders to improve and expand the delivery system for Medicaid services and access to care. The OCC will play a pivotal role in addressing assistance needs within communities by sharing with stakeholders, including Medicaid providers and hospitals, any best practices, resources, or other information regarding improvements to local service delivery systems.

Business and Regional Services

The Business and Regional Services associate commissionership is responsible for directing and administering assigned Enterprise support services and activities. These activities include Enterprise risk management and safety, Enterprise contract and procurement, facilities management and leasing, facilities support services for state schools and state hospitals, and regional administration operations.

Enterprise Risk Management and Safety

HHS Enterprise Risk Management and Safety (ERM) is responsible for the development, implementation, and continual evaluation of the risk management, safety, insurance, workers' compensation, and facility inspection programs designed to mitigate and manage losses incurred by the HHS Enterprise. In addition, this support area has oversight responsibility of risk management and safety for the DADS state schools and DSHS state hospitals.

ERM develops and provides risk management and safety training to enterprise agencies, and continually reviews risk management and safety training needs within HHS Enterprise. This support service group also provides safety planning for potentially dangerous or violent situations that arise in the workplace.

Additionally, ERM manages the HHS System interagency contract with the State Office of Risk Management (SORM) and completes the annual SORM 200 Annual Risk Management and Loss Report for each agency in the HHS System. ERM also coordinates and cooperates with SORM concerning workers' compensation, risk management and insurance issues, and serves as the primary SORM contact for the HHS Enterprise.

Enterprise Contract and Procurement Services

Enterprise Contract and Procurement Services (ECPS) is the purchasing authority for all agencies in the HHS System and is responsible for procurement functions. ECPS has an obligation to effectively and efficiently procure and contract for goods and services that support the administration of the HHS System and the consumer populations served. The purpose of the division is to direct and manage all procurement (purchasing and contracting) functions of the HHS Enterprise.

The mission of ECPS is to provide procurement services for HHS System administrative operations and client services operations that are performed by employees of the HHS System. ECPS performs a key role in the administration of activities involved in the procurement lifecycle to include:

- Identifying, defining, and assigning procurement related roles and responsibilities;
- Developing, implementing, and assessing the effectiveness of policies and procedures;
- Providing training, technical assistance, and tools such as policies and procedures, checklists, forms and templates to facilitate the procurement process;
- Performing supervisory review and quality assurance checks;
- Establishing, monitoring, and reporting on performance measures;
- Maintaining procurement related documents;
- Procuring administrative goods and services; and
- Procuring client goods and services.

Facilities Management and Leasing

Facilities Management and Leasing (FML) provides a variety of support services for the HHS Enterprise programs across Texas. This Enterprise support division is responsible for providing services such as state office mail processing and distribution, state office warehouse support and enterprise materials distribution, facility management and support for designated state office facilities, enterprise space planning and facilitation, and enterprise facility leasing.

FML ensures that facilities are safe, well maintained, and efficiently run. Additionally, they ensure that mail, warehouse and materials distribution support services are provided in an efficient and effective manner that meets the needs of

their designated clients. The division will continue enhancing communication and coordination in the HHS System to meet all agencies' needs for service delivery.

Facility Support Services

The Facility Support Services division provides support services for the DADS State Schools and DSHS State Hospitals (23 facilities) across Texas. The division provides both direct services, such as food delivery and centralized food buying, and indirect services, such as technical assistance, consultation and oversight. Services provided include maintenance and construction, computer-aided facilities management, risk management, real estate management, competency training and development, fleet operations, supply services, food, nutrition, laundry and environmental services, interstate compact coordination, and facility support performance indicators. The goal is to provide a system-wide integrated approach to support services within DADS State Schools and DSHS State Hospitals in order to streamline day-to-day business operations, allowing them to focus on direct consumer/patient care.

Regional Administrative Services

Regional Administrative Services provides support services for the HHS System's programs across the state of Texas in regional locations. Each of the 10 HHSC regional headquarters offices has a Regional Administrative Service Center accountable for services such as procurement and contract services, facility support services, facility management and leasing, financial management of the regional cost pool, coordination of regional administrative council, consultation services and asset and warehouse management.

The division provides a system-wide integrated approach to streamline day-to-day business operations by providing a customer driven, solutions oriented business environment for health and human services. The division will continue enhancing communication and coordination in the HHS System to meet the agencies' needs and exceed their expectations for service delivery.

Financial Services

Improving Financial Management Across the System

The financial services and related financial support functions of the HHS Enterprise operate under a framework that involves a coordinated approach to some functions and a consolidated or centralized approach to other functions. The organizational units at HHSC that provide these coordinating or centralized responsibilities are under the Deputy Executive Commissioner for Financial Services. These functions, which are critical to the performance of the HHS Enterprise, are the focus of continued optimization efforts, including further analysis of the extent to which additional consolidation may be beneficial.

The HHS Budget and Fiscal Policy section provides policy leadership for and coordination of budgeting, accounting and federal funds management for the five agencies of the HHS System. This unit provides direction on crosscutting financial issues, such as cost allocation methods, and assembles HHS Enterprise-level submittals of financial information. Among the key ongoing optimization activities are: developing quarterly HHS Enterprise financial status reports, building on the foundation of monthly status reports now prepared by each agency in the Enterprise; further exploration of options to maximize federal funding for HHS System; and analysis of financial services staffing patterns at the Enterprise agencies.

HHSC also provides four centralized functions that provide critical support to HHS System financial and program management. An economic analysis function provides research and analysis to support the efficient administration of HHS System programs with a particular focus on key factors driving costs in HHS System programs. Economic analysis staff, for example, is playing a lead role in the analysis of uncompensated care issues related to Texas hospitals. The HHSC Strategic Decision Support department provides information, analysis, and research that informs and supports key decisions regarding major programs, such as Medicaid and CHIP. Particular areas of emphasis are analysis of trends in cost factors and monitoring and forecasting of caseloads. A major ongoing initiative of Strategic Decision Support is leading the HHS System in expanding the use of business intelligence software providing refined inquiry and analytical capabilities to managers and staff throughout the HHS Enterprise.

Forecasting is another area where improvement efforts are ongoing. As an example, new methodologies are being evaluated for cost forecasting involving the use of encounter data, in addition to fee-for-service data. There is also strong emphasis on improving forecasting of costs for specific populations to support expansion of Medicaid managed care.

HHSC also provides centralized rate analysis functions for the HHS System. The primary focus is reimbursement rates and methodologies for Medicaid Services. Establishment of appropriate rates and rate methodologies continues to be critical for many Enterprise programs and presents particular challenges in supporting a service delivery system that continues to evolve with greater emphasis on managed care, development of new Medicaid waivers, and responses to hospital-related funding issues.

Enterprise Information Technology

Enterprise Information Technology (EIT) manages a variety of projects and efforts to serve the HHS System. Among the most significant projects are:

- ***Data Center Services***—As mandated by statute, the Department of Information Resources (DIR) is consolidating information technology—data centers and operations—for 27 state agencies. The contract commenced in March 2007. The first step in the process affected agency-operated services

and transitioned agency staff to the DIR's Team for Texas. The contract continues to evolve.

- ***Eligibility Systems***—As a result of multiple pieces of legislation in the 80th Legislative Session, HHSC is enhancing its eligibility determination system to meet new goals for better serving the public's needs.
- ***Data User Identity Management***—EIT is streamlining processes for users to access their information systems, and for EIT to determine quickly which users are qualified and which are not, so unqualified users may be screened out.
- ***Electronic Travel Vouchers***—Current practices for travel reimbursement require employees to submit hand-written forms. HHSC executive management has made it a high priority for EIT to develop and implement an electronic travel voucher submission system to improve efficiency.

Special Function Commission Offices

Legal Services

Office of Chief Counsel

The Office of Chief Counsel provides legal services to consolidated HHS Enterprise activities. This includes legal support for three kinds of oversight functions: consolidated administrative functions, consolidated compliance functions, and consolidated policy-making. Consolidated administrative functions support all HHS System agencies in functions such as human resources, purchasing, financial management, and contract management. Consolidated compliance functions support independent review and/or enforcement of external reporting requirements in such areas as civil rights, internal audit, and the inspector general. Consolidated policy-making involves HHS System-wide policy established by or on behalf of the HHS Executive Commissioner and applicable to all Enterprise agencies.

The Chief Counsel keeps HHSC executive management informed of Enterprise issues involving independent legal support. The Appeals Division manages cases such as HHSC client appeals (eligibility and Medicaid fair hearings) and employee grievance hearings for all HHS System agencies. Regional Legal Services provides legal support for consolidated HHSC regional administrative services across the state. Legal support provided to the HHSC Guardianship Program includes a variety of development and coordination activities, as discussed in the Challenges and Opportunities section of Chapter III.

Office of General Counsel

The Office of General Counsel provides in-house HHSC legal support of the agency's day-to-day agency operations, including: HHSC Council and advisory committee activities; contracting and procurement; Open Government compliance; ethics compliance; personnel management issues; rule development/submission;

legal support for HHSC programs; litigation, including tracking and outside counsel assistance; and representation in administrative hearings.

Chief Operating Officer

The Chief Operating Officer (COO) Division is responsible for the guidance and direction of all the administrative business operations and information resources, and oversight of expenditures relevant to the operations of HHSC. The COO Division consists of four units: Operations, Administrative Services Development, Commission Information Technology, and Policy and Special Projects.

The COO Division is a strategic partner in implementing HHSC's change initiatives and business innovation. The COO Division strives to develop and maintain a flexible, high-performance organization, to serve HHSC offices, programs, and customers through changes in both business climate and leadership. High performance includes ensuring administrative processes, staff resources, and technology tools are fully aligned with agency business process needs to produce exceptional results and excellent customer service.

Internal Audit

The HHSC Internal Audit Division (Internal Audit) performs objective, independent assurance and consulting services that provide timely and relevant information for use in managing risks and achieving more efficient and effective operations. To help achieve this, internal auditors review and evaluate HHSC's management control structure and governance processes. Working in partnership with management, Internal Audit provides executive management with assurance that risks are addressed and that the HHSC governance process is strong and effective.

Internal Audit's services include assessments of programs, processes, and systems under the responsibility of the HHSC deputy executive commissioners, and those programs, processes, and systems involving two or more agencies in the HHS System.

Internal auditors help management determine whether:

- Goals, objectives, and strategies are achieved;
- Risks are appropriately identified and managed;
- Financial, managerial, and operating information is accurate, reliable, adequately protected, and available when needed;
- Decision-making is appropriately coordinated and information effectively communicated;
- Resources are acquired economically, used efficiently, and protected adequately;

- Legislative or regulatory issues are recognized and addressed appropriately; and
- Employee actions are in compliance with policies, standards, procedures, and applicable laws and regulations.

HHSC Goal 2: Medicaid

HHSC will administer the state Medicaid system efficiently and effectively, using a comprehensive approach to integrate Medicaid client health services with other direct service delivery programs.

Target Population

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, older persons, and people with disabilities. Initially, the program was only available to people receiving TANF or Supplemental Security Income (SSI). During the late 1980s and early 1990s, Congress expanded program eligibility to include a broader range of people (older persons, people with disabilities, children, and pregnant women), and Medicaid eligibility is no longer linked to the receipt of cash assistance.

Children comprise the majority of Medicaid recipients but account for a relatively small portion of the expenditures. By contrast, the aged and people with disabilities make up just 22 percent of recipients, but account for 60 percent of Texas Medicaid spending on direct health care services. Figure 5.1 illustrates the percentages of the Medicaid population by client category and the portion of the Medicaid budget spent on each group in FY 2006.

The largest portion of the Medicaid population consists of women and children. As of August 2007, out of a total enrollment of 2,875,890, approximately 55 percent of the Medicaid population was female, and 74 percent was younger than 19 years of age. These groups are more likely to meet the eligibility criteria established for TANF, which provides them with automatic Medicaid eligibility. Medicaid eligibility is determined first, and eligibility for other programs is determined subsequently.

Figure 5.1
Texas Medicaid Beneficiaries and Expenditures, FY 2006

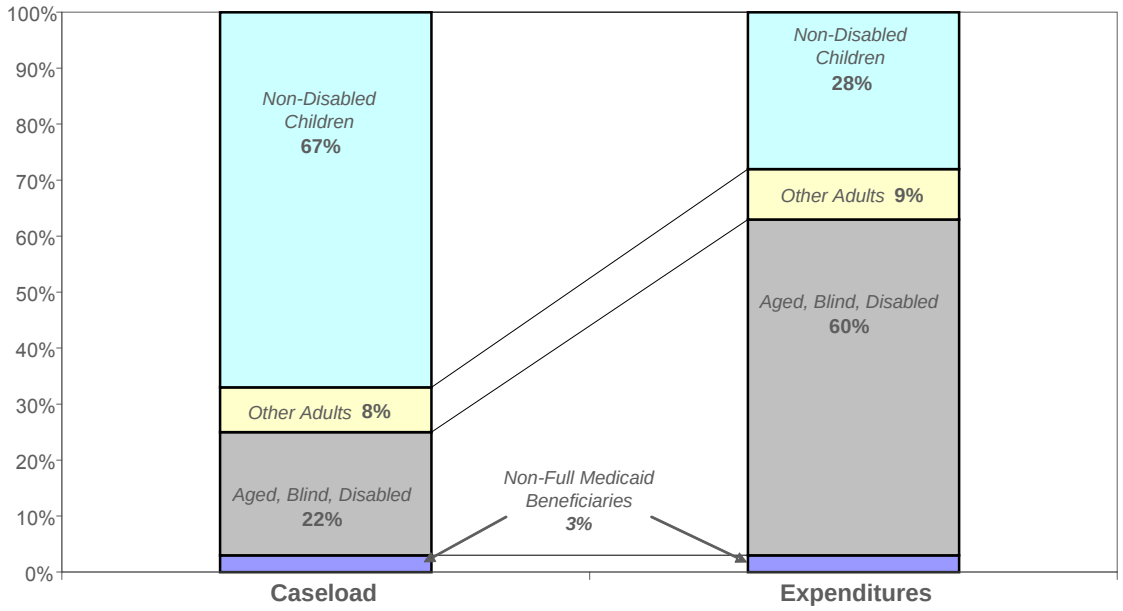


Figure 5.1: Estimated 2006 Medicaid Expenditures, CMS/PPS Systems. Notes: Aged, Blind, and Disabled includes clients under 21; Total Expenditures includes all Acute and Long-Term Care expenditures, including Vendor Drugs and Case Management. Expenditures and caseload for non-full Medicaid beneficiaries are not included.

The Social Security Administration (SSA) determines eligibility for SSI, the federal program that provides direct financial payments to low-income persons who are older, blind, or have disabilities. All SSI recipients in Texas are also categorically eligible for Medicaid, and they automatically receive Medicaid upon SSI determination. DARS is the disability determination agent for SSA in Texas.

Disability

As of August 2007, approximately 11 percent of the children and adults receiving Texas Medicaid services were eligible because of a disability. However, this figure understates the actual frequency of disabling conditions among Texans in the Medicaid program, because many persons 65 years of age or older also have a disability.

Gender

As of August 2007, females made up 55 percent of Medicaid clients. Texas Medicaid recipients are disproportionately female, for several reasons:

- Women live longer, on average. In 2007, 57 percent of the population 65 years of age or older was female.

- TANF beneficiaries are typically single-parent families, and in Texas, 93 percent of single-parent families receiving TANF are headed by females. Additionally, in 2006, 34 percent of single-parent families headed by a female lived below the poverty line, as compared to eight percent of two-parent families.
- Medicaid covers eligible low-income women for pregnancy-related services.

Age

As of August 2007, children and older persons made up 82 percent of Medicaid enrollees. Children younger than 19 years of age comprise 74 percent, or 2,122,314 of the 2,875,890 persons enrolled in the program. This figure includes children younger than 19 years of age who are SSI/disabled.

Ethnicity

Hispanics represented the largest proportion of Medicaid clients, comprising 54 percent of the Medicaid population, followed by Anglos (23 percent), and then African Americans (19 percent). In 2007, the state's composition of residents according to race/ethnicity was estimated as follows: 48 percent Anglos, 11 percent African American, and 37 percent Hispanic. All other population groups combined comprised the remainder.

Service Description

Medicaid is a means-tested entitlement program financed jointly by the state and federal governments and administered by the states. Medicaid pays for basic health care (physician, inpatient, outpatient, pharmacy, lab, and X-ray services). Medicaid also covers long-term care services and supports for older adults and recipients with disabilities. In August 2007, approximately one in nine Texans relied on Medicaid for health insurance or long-term care services and supports. As a result, the Medicaid program is the state's largest HHS Enterprise program.

The federal share of the jointly financed Medicaid program is determined based on average state per capita income compared to the United States (U.S.) average. This is known as the Federal Medical Assistance Percentage (FMAP). In Texas, the FMAP for federal FY 2008 was 60.56 percent. In federal fiscal year (FFY) 2009, the federal share decreased to 59.44 percent, and in FFY 2010 it is projected to be below 59 percent.

Texas Medicaid provides health care services to most clients through managed care systems. Medicaid managed care in Texas is administered by multiple organizations and programs, as described below.

State of Texas Access Reform Program

Medicaid's State of Texas Access Reform (STAR) is a managed care program for pregnant women, children, and TANF recipients. SSI clients without Medicare may choose to enroll in STAR in service areas without STAR+PLUS or ICM. STAR ensures the delivery of acute care services through contracts with a diverse range of health maintenance organizations, including local and national plans, provider-sponsored plans, independent non-profit plans, and for-profit plans. The STAR Program is currently available in the Bexar, Dallas, El Paso, Harris, Harris Expansion, Lubbock, Nueces, Tarrant, and Travis service areas.

Primary Care Case Management

Medicaid 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 managed care organizations.

NorthSTAR

NorthSTAR is an integrated behavioral health delivery system for Medicaid recipients in the Dallas service area. It is an initiative of 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.

Integrated Care Management

The 79th Legislature, Regular Session, 2005, directed HHSC to implement alternative models for people with disabilities. Integrated Care Management (ICM) is an innovative, non-capitated Texas Medicaid managed care program designed to address the complex care needs of people with disabilities or who are 65 or older. Specialized services, such as health care coordination and long-term services and supports, assist participants with their day-to-day activities. The ICM model serves mainly adults in the Dallas and Tarrant counties service areas. Through their parent or guardian, children may voluntarily participate in ICM. ICM participants began receiving services through the program in February 2008.

STAR Health

S.B. 6, 79th Legislature, Regular Session, 2005, directed HHSC and DFPS to develop a statewide health care delivery model for all Medicaid children in foster care. This model, STAR Health, serves a high-risk population with a greater need for services and helps better coordinate care. STAR Health services include medical, dental, vision, and behavioral health, as well as service coordination. Members began accessing services through STAR Health on April 1, 2008. Some specially designed STAR Health features are listed below:

- Health Passport—A web-based electronic medical record;
- Mid-month Eligibility and Enrollment—Coverage is effective upon entering conservatorship; and
- Medical Home—Each child will have a medical home with a primary care physician. The primary care physician can be changed, as needed.

Women's Health Program

HHSC implemented the Women's Health Program (WHP) on January 1, 2007. WHP extends eligibility for Medicaid family planning services to eligible women 18 to 44 years of age with incomes up to 185 percent of the federal poverty level (FPL). The goal of WHP is to avert unintended, Medicaid-paid births by expanding access to family planning services. WHP is projected to save $441 million over five years, $276 million in state savings and $165 million in federal savings, by reducing Medicaid-paid births and associated costs, such as Medicaid coverage for newborns. As of January 2008, 76,000 women were enrolled in WHP.

Personal Care Services

Medicaid covers Personal Care Services (PCS) for clients younger than 21 years of age who require assistance with activities of daily living, instrumental activities of daily living, or health-related functions because of a physical, cognitive, or behavioral limitation related to their disability, physical or mental illness, or chronic condition. Effective September 1, 2007, administration of the PCS Medicaid benefit for children transitioned from DADS to HHSC. The rationale for the transfer was associated with improved coordination of PCS with other Medicaid benefits for children, i.e., Durable Medical Equipment, private duty nursing, and home health.

As a part of the transition, HHSC developed an interim assessment tool to determine children's needs for PCS. As part of a longer-term strategy, Texas A&M University is developing a child-unique assessment tool relative to PCS and private duty nursing. To administer these assessments, an additional 56 full-time equivalent positions were allocated to DSHS, located throughout the state. In August 2008, Texas A&M will conduct training for all HHSC and DSHS staff involved in the effort, and use of the assessment tool will begin in September 2008.

Trends and Initiatives

Trend: Eligible Populations

The number of Texans participating in the Medicaid program has increased in the last several years. Figure 5.2 shows the number of Medicaid enrollees for selected fiscal years. From FY 2000 to FY 2007, the average monthly enrollment in the Medicaid program grew from 1,807,669 to 2, 832,210, an increase of approximately 57 percent.

Figure 5.2
Texas Medicaid Enrollment, Fiscal Years 2000-07

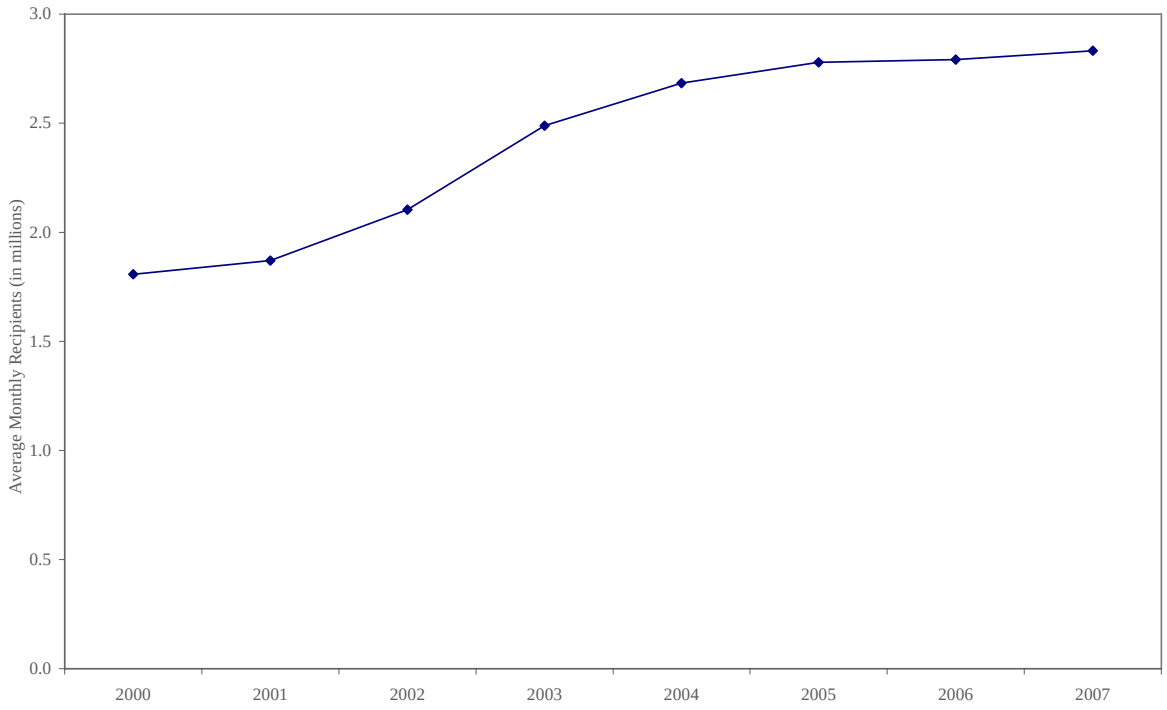


Figure 5.2: HHS System Forecasting, 2008.

Research also shows that the number of Texans in key program categories who could be potentially eligible to receive Medicaid benefits is expected to continue growing. The Medicaid eligible population is also projected to continue growing during the planning period of 2009-13.

- The number of qualified pregnant women older than 18 and younger than 45 and living at or below 185 percent of poverty for at least one month of the year will grow from 170,000 in 2009 to 184,000 in 2013, an 8 percent increase.

- The number of infants at or below 185 percent of poverty for at least one month of the year will grow from 293,000 in 2009 to 311,000 in 2013, a 6 percent increase.
- The number of children 1 to 5 years of age who are at or below 133 percent of poverty for at least one month of the year will grow from 948,000 in 2009 to 1,015,000 in 2013, a 7 percent increase.
- The number of children 6 to 18 years of age who are at or below 100 percent of poverty for at least one month of the year will increase from 1,440,000 in 2009 to 1,537,000 in 2013, a 7 percent increase.

Trend: Medicaid Managed Care

Both in Texas and nationally, Medicaid programs have increasingly turned to managed care systems to more effectively deliver services. Texas Medicaid began implementing managed care in 1993. As of January 2008, the number of Medicaid managed care enrollees was approximately 2,288,692, or more than 85 percent of the state's Medicaid population.

Initiative: Tailored Benefits Package

S.B. 10 directs HHSC to develop a tailored benefit package that is customized to meet the health care needs of Medicaid children with special health care needs. Children enrolled in and receiving the tailored benefit package will remain eligible for the full set of Medicaid benefits for which they are currently entitled. One option available to HHSC is to implement a delivery system to improve care through increased care coordination.

Initiative: Pilot Program to Reward Healthy Behaviors

S.B.10 requires HHSC to implement a pilot program in one region of the state to provide positive incentives to Medicaid clients that lead healthy lifestyles. Positive incentives can be provided to individuals to support healthy lifestyle choices, including participating in certain health-related programs or engaging in certain health-conscious behaviors, resulting in better health outcomes for those recipients.

In implementing the pilot, HHSC may provide:

- Expanded health care benefits or value-added services for Medicaid recipients who participate in certain programs, such as specified weight loss or smoking cessation programs;
- Individual health rewards accounts that allow Medicaid recipients who follow certain disease management protocols to receive credits in the accounts that may be exchanged for health-related items specified by HHSC that are not covered by Medicaid; and
- Any other positive incentive HHSC determines that promotes healthy lifestyles and improves health outcomes for recipients.

HHSC is required to consider similar incentive programs implemented in other states to determine the most cost-effective measures to implement the pilot program. HHSC is reviewing options for implementation.

Initiative: Researching Ways to Incorporate Electronic Health Information Exchange

STAR Health is a comprehensive health care program for children in foster care that was implemented April 1, 2008. HHSC has developed a Health Passport for each child in STAR Health containing a summary of his or her medical information. The Health Passport is available through the Internet and makes it easier for doctors and caregivers to obtain accurate medical information on each child. As a result, children in foster care are expected to receive better health care with fewer repeated services.

S.B.10 encourages the development of electronic health records to improve patient care in Medicaid. HHSC is currently conducting a feasibility study to determine appropriate ways to incorporate health information technology (HIT) for all children enrolled in Medicaid and CHIP younger than 19 years of age. The study will examine national HIT projects and determine the feasibility of building on current Texas HIT initiatives, including the Foster Care Health Passport and the Medicaid Access Card. As part of the study, HHSC will also research e-scribing, an electronic exchange of medication information between physicians and pharmacies.

Initiative: Nurse Family Partnership

S.B. 156, 80th Legislature, Regular Session, 2007, directed HHSC to implement the Nurse-Family Partnership (NFP) Competitive Grant Program to serve approximately 2,000 families in Texas.

NFP is a nurse home visitation program model that works to improve the pregnancy outcomes, child health and development, and parents' economic self-sufficiency of low-income, first-time parents, and their child. Through the program, registered nurses begin visiting Medicaid-eligible first-time pregnant women no later than the second trimester and continue to visit the families until the child turns two years old.

The Texas program is based on a national model that has shown consistent outcomes of improved prenatal health, fewer childhood injuries, and improved school readiness. HHSC posted a request for proposals for NFP grants in February 2008, and anticipates funding program sites in FY 2009.

Initiative: Specific Frew Initiatives

Below are several *Frew* Strategic Initiatives that have been approved for funding by the LBB and the Governor's Office. They include:

- **First Dental Home—**This proposal allows dentists enrolled in Medicaid to provide an oral evaluation, apply fluoride varnish, and educate parents about

proper oral hygiene for their children who are six months of age or older. After receiving training, pediatric dentists can begin billing Medicaid for this service in March 2008, and general dentists may begin billing in May 2008.

- **Oral Evaluation and Application of Fluoride Varnish in the Medical Home—**This proposal allows primary care providers enrolled in Medicaid to provide an oral evaluation, apply fluoride varnish, and educate parents about proper oral hygiene for their children who are six months of age or older. The primary care provider would then refer the Medicaid child to a dental provider for future dental services. After receiving training, primary care providers can start billing Medicaid for providing this service in the fall of 2008.
- **Mobile Dental Unit in the Valley—**This proposal allows dental teams from the University of Texas Health Science Center in San Antonio Dental School to provide services to underserved regions of the Valley, including Starr, Duvall, and Zapata counties. Clients without a medical home would be referred to a regular source of care, as well. The mobile dental unit will begin providing services in the fall of 2008.
- **Integrated Pediatric and Mental Health Pilot—**This pilot has received expenditure authority by the LBB and the Governor's Office. The pilot will improve access to mental health services provided to children in their medical home. HHSC will fund six pilots throughout the state in urban, rural, and academic settings.
- **Subspecialty Access Improvement—**This proposal allows pediatric subspecialists to receive Medicaid reimbursement for consulting with a primary care provider, and it funds the development of referral guidelines for primary care providers to use when referring to pediatric subspecialists.

These five initiatives will cost less than $40 million in the 2008-09 biennium. HHSC anticipates sending additional projects to the LBB and the Governor's Office for approval, as proposals are reviewed and recommended by both an independent advisory committee (*Frew* Advisory Committee and HHSC).

HHSC Goal 3: Children's Health Insurance Program

HHSC will ensure health insurance coverage for eligible children in Texas.

Target Population

CHIP assists families who have incomes too high to qualify for Medicaid but who cannot afford private health insurance. The federal government provides matching funds to states for health insurance coverage for children in families with incomes below 200 percent of the FPL.

Service Description

The federal Balanced Budget Act of 1997 established CHIP under Title XXI of the Social Security Act. In response to this legislation, Texas began covering uninsured children from birth through 19 years of age in CHIP in May 2000. Texas CHIP benefits cover a full range of services, including regular checkups, immunizations, prescription drugs, lab tests, x-rays, hospital visits, and other services.

The 79th Legislature directed implementation of the CHIP Perinatal Program, which provides CHIP coverage for prenatal care services to the unborn child of a pregnant woman and regular CHIP coverage to the infant after birth. The CHIP Perinatal Program provides 12 months of continuous coverage for unborn children up to 200 percent of the FPL. The benefit allows Texas to provide prenatal care to a larger population while drawing down federal matching funds.

Trends and Initiatives

The average enrollment levels for CHIP, as stated in the 2008-09 General Appropriations Act (Article II, Health and Human Services Commission, H.B. 1, 80th Legislature, Regular Session, 2007), are 397,683 in FY 2008, and 401,578 in FY 2009. This appropriation includes CHIP Perinatal caseload, with 65,317 perinates in FY 2008 and 69,316 in FY 2009. The appropriated caseload without perinates is 331,866 in FY 2008 and 332,262 in FY 2009. However, an additional appropriation was made in H.B. 109 which restored some of the CHIP eligibility policies that had been eliminated beginning September 2003. H.B. 109 appropriated funds to cover 66,668 additional clients in FY 2008 and 96,396 additional clients in FY 2009. CHIP enrollment began increasing in 2007 and grew from 300,262 in August 2007 to 352,891 in December 2007. HHSC anticipates the caseload will continue to increase in the 2008-09 biennium due to enrollment in the CHIP Perinatal program and policy changes enacted during the 80th legislature, as discussed below.

In 2007, more than 60 percent of children on CHIP were between 6 and 14 years of age, and only 0.3 percent were younger than 1 year old. The higher proportion of CHIP clients in the older age groups is due in part to the different income eligibility requirements for CHIP and Medicaid. Medicaid allows families with younger children to have higher income limits, and allowable family income for Medicaid decreases as children age. With the implementation of the CHIP Perinatal program, the proportion of CHIP clients younger than 1 year old is expected to increase.

Certification Period and Enrollment Fee

H.B. 109 directed the following changes in CHIP to be implemented on September 1, 2007:

- Extending the enrollment period to 12 months;
- Eliminating the 90-day waiting period for most children;
- Increasing the asset limit from $5,000 to $10,000 per household;

- Increasing the vehicle value exclusion amounts;
- Allowing child care expenses to be deducted from household income when determining whether children are eligible for the program; and
- Requiring an income check for households with income levels above 185 percent of the FPL during the sixth month of eligibility to determine whether the household remains income eligible for CHIP.

CHIP enrollment fees are paid every 12 months and are determined on a sliding scale. There is no enrollment fee for the lowest-income families, and families earning the upper limit for the benefit pay up to $50 per 12-month enrollment period.

Families with incomes above 185 percent of FPL have their incomes reviewed in the sixth month of coverage. HHSC notifies these families if additional information is needed or if the review finds that the family's income has changed.

HHSC anticipates that changes directed by H.B. 109 will increase enrollment in CHIP, and that the changes will eliminate the risk for most children of disenrollment at any point during the 12-month eligibility period.

The Children's Health Insurance Program Perinatal Program

The CHIP Perinatal Program provides CHIP benefits to unborn children of pregnant women who are ineligible for Medicaid due to income and/or immigration status. Pregnant women ineligible for Medicaid due to immigration status, and who have income at or below 185 percent of the FPL, and who are enrolled in the CHIP Perinatal program, must also apply for Emergency Medicaid to cover their hospital labor with delivery. In CHIP Perinatal, the unborn child receives 12 months of continuous eligibility beginning the month of eligibility determination.

On July 13, 2007, the federal CMS revised the federal rule on the length of Medicaid coverage for newborn children born to women who are on Medicaid at the time of giving birth. The revised rule requires states to grant 12 months of continuous Medicaid eligibility to newborns, regardless of the mother's immigration status, as long as the mother was receiving Medicaid, including Emergency Medicaid, at the time of birth. The revised rule may impact the CHIP Perinatal Program.

HHSC Goal 4: Encourage Self-Sufficiency

HHSC will encourage and promote self-sufficiency, safety, and long-term independence for families.

Temporary Assistance for Needy Families

Target Population

The TANF caretaker population in Texas is composed predominately of African-American or Hispanic women with the following characteristics:

- An average age of 30 years;
- One or two children younger than 12 years of age;
- Unemployed and have no other income;
- Receiving a TANF grant of $244 or less; and
- More than half (59 percent) of adults in single-parent cases have 12 or more years of education.

The primary welfare reform initiative within the TANF program is Texas Works, which encourages people who apply for or receive TANF benefits to find employment. Every adult who applies for TANF benefits is advised of personal responsibility, time-limited benefits, and the requirement to work toward self-sufficiency. Many TANF recipients or potential recipients also face self-sufficiency issues including lack of affordable child care and reliable transportation when attempting to enter the labor market. The Texas Works program refers applicants to the Texas Workforce Commission (TWC), in accordance with current law, for employment and job training services. TWC staff also work with clients to:

- Identify ways to help working clients and former clients retain employment and advance toward a career;
- Act as advocates for needed community services, such as child care and transportation;
- Promote and advocate for community collaboration to identify, develop, and expand resources needed to promote independence;
- Promote transitional Medicaid and child care services for those who qualify;
- Contact employers to follow up on employment leads; and
- Follow up with working clients and former clients to support their continued employment and career progress.

The average monthly TANF grant amount in Texas was $151 per consumer in FY 2007. At the current payment level, with the value of Food Stamps and Medicaid added, the average TANF child lives in a home with an income equal to 79 percent of the FPL.

By August 1999, the TANF caseload had declined almost 57 percent from its high point in January 1994, due to significant program changes implemented following the passage of the federal Personal Responsibility and Work Reconciliation Act in 1996 and H.B. 1863, 74th Legislature, Regular Session, 1995. The Personal Responsibility Agreement requires a family to comply with requirements about work, child support, school attendance, THSteps, parenting skills, and refraining from drug

or alcohol abuse. If any of these requirements is not met, the entire family loses cash assistance, and the caretaker must demonstrate compliance before the family can be reinstated. In February 2006, the TANF caseload was 69,200. The TANF caseload has continued to decline, and in February 2008, the caseload was 51,516 – a decrease of 25 percent.

It is likely that many more Texans are eligible for TANF benefits than are currently receiving assistance. Current projections indicate the average monthly number of actual recipients will decline from 145,807 recipients in FY 2007 to 139,666 recipients in FY 2009, a decline of 4 percent. However, the number of recipients is projected to grow slightly from FY 2008 to FY 2009.

Service Description

The TANF program provides financial help for children and their parents or relatives living with them who are below income and resource limits set for the program. Two-parent households can receive assistance through the TANF State Program if the family meets income and resource criteria. Assistance is typically provided on a monthly basis, but it may be provided as a once per year emergency cash assistance payment of $1,000 if the family meets crisis criteria.

Trends and Initiatives

Changes in Federal Law and Policy

The federal Deficit Reduction Act of 2005 reauthorized the TANF program and included the following provisions:

- States must adjust their baseline year for caseload reduction credit from 1995 to 2005. Texas will receive credit for caseload declines that occur from FY 2005 forward, excluding those declines that result from policy changes further restricting eligibility.
- The federal work participation rate standards of 50 percent for single parent families and 90 percent for two-parent families were maintained and separate state programs, funded with TANF maintenance-of-effort (MOE), were included in the calculation of the federal work participation rate. Texas is not required to report or meet the two-parent rate because the 80th Legislature did not fund the two-parent separate state program with MOE.

Electronic Benefits Transfer

The EBT program, managed by Lone Star Business Services within the Office of Family Services, provides TANF and food stamp recipients access to benefits 24 hours a day, 7 days a week. Using a state-issued Lone Star debit card, recipients purchase goods and receive cash from authorized retailers. Since the program began in 1994, the Lone Star EBT system has processed approximately $28 billion in program benefits.

The agency received an appropriation of $1.6 million in exceptional item funding for EBT migration to a Unix operating environment for the 2008-09 biennium. A transformation project to upgrade the EBT system hardware and move to the IBM AIX operating system began in September 2007, and is currently scheduled for completion in January 2009. The primary goals of this project are:

- To move the EBT application to a new operating environment at the Austin Data Center managed by Team for Texas under the Data Center Services contract with DIR, and
- To upgrade the EBT to the latest release of the Sybase database management system software.

Food Stamps

Target Population

Food insecurity is a concern for many low-income Texans. The U.S. Department of Agriculture (USDA) defines food insecurity as inadequate access to food to meet basic needs. The USDA recently released its 2006 study on food insecurity, and Texas has the third highest rate of food insecurity at 16 percent, as compared to the national average of 10.9 percent.

The Food Stamp households in Texas are predominately of Hispanic or Anglo women with the following characteristics:

- An average age of 30 years;
- One or two children younger than 18 years of age;
- 75.2 percent of households receive some income;
- 13.3 percent of heads of households are employed full time;
- 20.5 percent of heads of households are disabled; and
- 47.1 percent of recipients 18 years of age or older have an education level of 12 years or more.

The average number of households served by the Food Stamp program each month increased from 965,139 in FY 2005 to 988,681 in FY 2007, an increase of approximately 2.4 percent.

Current projections indicate that the number of eligible recipients will grow from 2,486,495 in FY 2007 to 2,569,722 in FY 2013, an increase of approximately 3.3 percent. Households receiving Food Stamps are projected to increase from 970,143 in FY 2007 to 1,006,510 in FY 2013, a growth rate of approximately 3.6 percent.

In January 2000, Texas began outreach efforts for the Simplified Nutrition Assistance Program (SNAP) for older SSI participants. The program began in October 2001, adding approximately 60,000 people to the Food Stamp program. For FY 2007, there were approximately 68,970 recipients in the program.

Service Description

The nutrition assistance program, or Food Stamps, is a federally funded entitlement program that helps low-income families buy nutritious food from local retailers. Food stamp benefits are 100 percent federally funded and administrative costs are 50 percent federally funded.

Trends and Initiatives

Electronic Benefits Transfer

See this topic described above, in the TANF discussion.

Various Trends and Initiatives

The Food Stamp program plans to accomplish the following during this planning period:

- Renewal of the SNAP waiver, expected to occur in September 2008;
- Implementing policy, process, and automation changes as needed as Congress continues to consider the Farm Bill Extension Act of 2007, not yet passed, which is planned to cover farm programs through 2012;
- Addressing the Farm Bill's requirement to charge states 5 percent of the administrative costs if the state is more than 50 percent above the national negative error rate for two consecutive years; and
- Conducting outreach through food retailers, in accordance with H.B. 3571, 80th Legislature, Regular Session, 2007.

2-1-1 Texas Information and Referral Network

Target Population

The 2-1-1 TIRN, as described in the Challenges and Opportunities section of this chapter, serves the entire population of Texas. 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.

Service Description

In 1997, TIRN was designated by the 75th Legislature as the HHSC program responsible for the development, coordination, and implementation of a statewide information and referral network. A major component of this effort has been the implementation of the state's 2-1-1 telephone system, which is a single, statewide number that consumers can dial for information about community resources. HHSC received approval from the Federal Communications Commission and the Public Utilities Commission for the abbreviated dialing code, developed the network platform, provided the necessary telephony, and started regional operations in 2002. Statewide access was achieved in July 2004.

Through a decentralized system of 25 private partnerships, in 2007 2-1-1 TIRN handled more than 1.9 million calls for general information and referral. Most of the time, 2-1-1 TIRN meets its high standard of answering 80 percent of calls within 60 seconds or less.

The 2-1-1 network in Texas has been expanded to provide telephone access to information about eligibility for programs administered by HHSC. The integrated voice response system guides the caller through a menu of services and options regarding the programs, including Food Stamps, Medicaid, CHIP, TANF, cash assistance, nursing home care, managed care enrollment, THSteps, WHP, and the Lone Star Card. All choices have an option to connect the caller to a customer service representative located in one of the eligibility support services call centers.

Trends and Initiatives

Serving Military Service Members

To help implement S.B. 1058, 2-1-1 TIRN is working with the Adjutant General's Department and other state and federal agencies to develop a referral program to provide information on reintegration services to military service members, their families, and their dependents.

Evolving Responsibilities Regarding Disaster Events

A particularly vital part of 2-1-1 TIRN's work is to implement its responsibilities in accordance with the *Texas Homeland Security Strategic Plan of 2005-2010*. TIRN takes an extensive role in providing disaster and emergency information to the public, including serving as the initial point of contact for the Transportation Assistance Registry, which coordinates efforts to help people with special needs evacuate before a disaster. In 2007, TIRN purchased a Disaster Kit (d-kit) to ensure rapid expansion of phone capacity during a disaster event. The d-kit provides 36 phone lines, which can be added to the system to help with:

- An extraordinarily heavy call volume in the event of a disaster, and
- A temporary replacement if one of the 25 Area Information Centers (AICs) were to become unable to function and or need to relocate due to evacuation or building destruction.

The d-kit has the capacity to receive inbound calls, to make outbound calls, and to transfer calls to any AIC within the 2-1-1 Texas network.

Increasing Referrals to Children's Services

Outreach and public education efforts have increased awareness of 2-1-1 TIRN as a source for child care and early education information and could require additional resources to support the increased call volume. To implement H.B. 2048, 79th Legislature, Regular Session, 2005, 2-1-1 TIRN expanded its website (www.211texas.org) to include information about public school programs such as pre-kindergarten programs, after-school programs, and other programs related to

the care and education of children. TIRN collaborated with TWC, the Texas Education Agency, the University of Texas Medical Center's Pre-K Project, and the Head Start Collaboration Project to develop the content needed to expand the site. People using the website may search for these services by type of services needed, age, and/or facility type. The website also includes an e-mail form for parents and guardians to request applications to programs that interest them, such as government-assisted child care and educational services.

Maximizing Technology

To maintain use of state-of-the-art technology, 2-1-1 TIRN updates its equipment, including the d-kit described above and a new regional routing design, to ensure calls are answered as quickly as possible.

Most urgently, TIRN must address the challenge that the decentralized resource database system that supports 2-1-1 Texas delivery of resource information that is provided to the caller is not linked to the telephony system or centrally accessible. Each regional call center utilizes independently procured database software that cannot communicate with back up regional call centers, nor seamlessly upload the resource database to the centralized database at www.211texas.org. Each monthly transfer requires data clean up on the part of the regional call center and the state staff supporting the centralized database. In addition to the resource database clean up, no mechanism exists to centralize caller data.

The increased call volume compels TIRN to seek alternatives for providing information and referral service to 2-1-1 callers. These added features and functionality would result in an increase for the productivity of call specialists, the state's ability to gather caller data, and the quality of service the caller receives.

Refugee Assistance Program

Target Population

Texas remains among the top four States for refugee arrivals following Florida, California, and New York. The state receives approximately 4,000 – 4,500 refugees annually. The Refugee Assistance Program (RAP) provides refugee services for all who meet all requirements of 45 Code of Federal Regulations 400.43. In addition, persons granted asylum are eligible for refugee benefits and services from the date that asylum was granted. Victims of severe forms of trafficking and their immediate family members, who have received a certification or eligibility letter from the Office of Refugee Resettlement (ORR), U.S. DHHS, are eligible from the date on the certification letter.

Arrivals have been steadily increasing for the past three years since the unprecedented reduction of arrivals following September 11, 2001. It is anticipated that resumption of pre-9/11 levels of arrivals will continue and will be reflected in the number of clients served. However, the number of clients served and anticipated to

be impacted by available federal funding and allocations. While funding has increased, the amount is moderate and, until congressional appropriations increase significantly to meet demand, LBB performance measures will remain at the current level.

Service Description

HHSC administers the RAP, which is 100 percent federally funded by the ORR. The purpose of the program is to help people who are eligible for refugee services to become self-sufficient as quickly as possible after arriving in the U.S. and to help them integrate successfully into their new communities.

During FY 2007, the RAP provided refugee services to a total of 7,799 clients eligible for refugee services. Services included cash and medical assistance benefits, social services, including case management, employment assistance, and education, including English language instruction.

Discretionary grant programs including services for older refugees, refugee women, Cuban arrivals, and refugee school children are also provided. In addition, the program funds the Refugee Health Screening program through the DSHS and the Unaccompanied Refugee Minor program through DFPS. As part of the assistance provided to refugees adjusting to life in a new culture and community, some refugee service providers offer parenting classes or provide referrals to local community resources.

The RAP has accomplished the following since the last strategic planning cycle:

- Continued strong, collaborative working partnerships with the following organizations:
  - Refugee Resettlement Agencies;
  - Federal funding partners, ORR, and State Department Population Refugee Migration Department;
  - National Refugee Voluntary Agencies (VOLAGs) (all nine national VOLAGs are represented in Texas);
  - State Interagency departments;
  - Other state refugee programs and State Coordinators of Refugee Resettlement (SCORR);
  - Department of Homeland Security and asylum districts;
  - National Research groups (Urban and Lewin groups); and
  - Other national technical assistance groups, such as Bridging Refugee Youth and Children Services, Spring Institute, and the Institute for Social and Economic Development;
- The RAP has a leadership role at the national level and serves on the Executive committee for SCORR;

- Discretionary grant funding was received for the first time in Texas to assist Cuban/Haitian entrants and refugees; increased funding was also received under discretionary grants to serve refugee women, older refugees, and refugee school children; and
- HHSC will continue the successes of the RAP and ensure people in target groups have timely access to services, programs and benefits.

Trends and Initiatives

The Refugee Affairs Program sets annual federal and state goals to meet the needs of newly arriving refugee populations. The program plans to accomplish the following:

- Continuing to expand the statewide Texas Consortia of Refugee Providers, a group of governmental and non-governmental organizations and refugees dedicated to improving services for refugees resettled in Texas;
- Coordinating with DADS and DFPS, maintain an updated curriculum for agency staff regarding older refugee populations, refugee children, and victims of trafficking, and
- Maximizing federal and state funding through a coordinated and integrated approach with refugee service providers, increasing refugee inclusion in mainstream services, and developing internal and external program activity assessments, available resources, and strategies.

Disaster Assistance

Target Population

The Texas Disaster Act of 1975, in conjunction with the federal Disaster Relief Act, authorizes financial grants to individuals and households with disaster-related necessary expenses and serious needs, such as transportation, personal property, and medical, dental, and funeral expense, in counties where the U.S. President has declared major disasters. The program is available to all people who qualify regardless of race, sex, religion, color, or national origin. U.S. citizens, non-citizen nationals, or qualified aliens in the U.S. may apply, or a parent of a minor child who meets any of these conditions may apply on the minor child's behalf.

Any head of a household in the declared major disaster area may apply for an IHP grant. Both homeowners and renters may apply. Household members not classified as dependents by the Internal Revenue Service must apply separately. People visiting or passing through the area who had damages when the disaster occurred may also be eligible.

Service Description

HHSC provides disaster assistance services under the federal assistance to Individual and Households Program, which is a federal/state program administered

by the Federal Emergency Management Agency and HHSC. HHSC disaster assistance also includes identifying, obtaining, and delivering available food, water, and ice to shelters and bulk distribution centers. HHSC responds to emergencies and disasters, such as Hurricanes Katrina and Rita, with necessary access to eligibility services for Food Stamps, Medicaid, and TANF benefits.

As of February 2006, Hurricane Katrina evacuees in Texas have received $34.6 million dollars in Medicaid benefits and $36.6 million dollars in Food Stamps benefits.

Information about the HHSC program is located at:
https://hhsportal.hhs.state.tx.us/ws_dappWeb/public/jsp/countyWebReport.jsp.

Trends and Initiatives

During the past 26 years, Texas has had 52 disasters, such as floods, hurricanes, tornados, severe storms, and fires. Since 1974, expenditures have totaled approximately $628 million in assistance provided to households impacted by disasters. Ten major disasters have been declared in Texas since 2002, and the program has aided more than 110,934 households and provided $164 million dollars in assistance.

Family Violence Program

Target Population

The Family Violence Program (FVP) serves victims of violence who have been physically, emotionally, and/or sexually abused by a family or household member. In 2006, the Texas Department of Public Safety (DPS), together with the Texas Council on Family Violence, reported that 120 women were killed by their intimate partner. Additionally, 186,868 incidents of family violence were reported in the state.

Service Description

The goal of the FVP is to promote self-sufficiency, safety, and long-term independence from family violence for adult victims and their children. The strategy to meet the goal is to provide emergency shelter and/or support services to victims and their children, educate the public, and provide training and prevention support to various agencies.

Under the authority of the Texas Human Resources Code, Title 2, Chapter 51, the FVP contracts with nonprofits to provide direct services to victims of family violence. These services fall under three categories: shelter centers, nonresidential centers, and special nonresidential projects. Since its beginning as a pilot project, the FVP has grown from contracts with 6 shelter centers in 1979 to 72 shelters, 8 nonresidential centers, and 21 special nonresidential projects in 2008. In addition to allocating funds, the FVP develops rules and policies, monitors adherence to state

and federal rules, provides technical assistance to programs, and collects and maintains program data.

Trends and Initiatives

Family violence continues to be a complex issue with multiple barriers affecting a victim's ability to achieve self-sufficiency. The lack of access to emergency shelter, transitional and affordable housing, and affordable child care make it difficult for a victim to leave the relationship. Additionally, economic instability and immigration issues are leading causes of victims remaining in shelters longer. Residential and nonresidential centers are facing clients with more complex issues related to mental health, substance abuse, and physical and mental disabilities. Victims with more complex issues require more intensive and specialized services and resources. Many family violence providers have indicated a need to develop capacity in these areas and in working with people of color, immigrants, and senior citizens.

There is an increased need for services for children who have witnessed and/or been direct victims of family violence. Children who witness family violence may exhibit atypical child behaviors such as low self-esteem, high aggression, low coping skills, poor academic performance, and isolation. In addition to counseling services, many family violence providers offer parenting classes or provide referrals to local community resources.

The Exceptional Item Funding for the 2008-09 biennium will allow FVP to fund specialized services focused on prevention, legal support, and economic stability to some FVP providers. These service areas are crucial to assisting families in leading lives in which they are self-sufficient and free from violence. There is a need to continue to support these newly funded specialized services and to increase the availability of specialized services across the state.

Currently, providers receive monitoring every two years. The site visit tool for FVP providers was revised to include:

- More comprehensive measures to monitor quality of service provision,
- Additional fiscal reviews, and
- Opportunities to discuss with providers best practices and challenges in the field.

FVP's current performance measures are based on provider outputs (what the providers have done) versus outcomes (improved client success). The performance measure related to incidence of family violence in Texas is based on a survey completed in 1989. Additionally, FVP has a goal to design and implement deliverable-based measures with providers. For a transition to outcomes that accurately capture the effect of family violence services on victims and their children, FVP will need additional resources. The transition to these outcomes must be inclusive of community partners, must measure success, and must reflect the work of providers.

Many family violence providers received reductions in their Victims of Crime Act (VOCA) funding, and accordingly, providers have been unable to increase their service delivery. Family violence providers have also become more dependent on HHSC funding because of the reductions.

FVP continues to develop a new data collection system. With more stringent federal confidentiality guidelines around the collection and storage of data related to victims of family violence, FVP is working to develop a system that is meaningful and useful to HHSC and FVP providers. Additionally, FVP is developing automated systems within the application in order to streamline contract monitoring processes.

Over the next few years, FVP intends to develop stronger relationships with providers, increase direct technical support, and work in partnership on funding, monitoring and service provision strategies.

Initiatives to maximize resources and improve services include the following:

- Planned program growth, using funding for expansion of residential and nonresidential services;
- Supporting the continuation of services to underserved populations;
- Continued collaboration with other agencies on initiatives and services for victims of domestic violence; and
- Assessing current provider funding and monitoring strategies to ensure high quality of service to victims of family violence and increased accountability of FVP providers.

The following identify the challenges facing the FVP in the next few years:

- More stringent confidentiality provisions in the federal Violence Against Women Act alter the method in which FVP can collect data from providers;
- The six-year trend in the increase of adults being denied shelter due to lack of space; and
- Federal funding cuts of $35 million associated with the VOCA, affecting Texas providers receiving VOCA funding.

With the following opportunities, FVP will reach program goals in the next few years:

- New data applications that increase validity and reliability of data received from providers;
- Increased contract monitoring and oversight to ensure quality of services, provide technical support, and build stronger relationships with community partners;
- Performance measures that ensure provider and program efficacy and reflects current family violence data; and

- Specialized services associated with Exceptional Item Funding for the 2008-09 biennium (e.g. primary prevention, economic stability, legal support).

Community Education and Outreach Services

Target Population

These programs target people who are potentially eligible for state and federal benefit programs and who have not applied for assistance. Some people do not know about the benefit programs or face barriers accessing them.

Service Description

Outreach efforts for the Food Stamp, CHIP, and Children's Medicaid will decrease the barriers that potential clients face in accessing and understanding these programs. Texas is also experiencing an increase in obesity and diabetes. Nutrition education helps combat these problems with focused education taught specifically to the low-income population served by the food stamp program. The great need for these programs drives a continual need for expansion of services. As program capacity increases, administrative work increases due to monitoring requirements and technical support to a larger number of contractors. This growth will require an increase in state staffing to meet these requirements and demands.

Community Education and Outreach Services efforts include:

- **Education and Administrative Reporting System—**This new federal reporting system will begin in FFY 2008 and will report information on direct education, social marketing, indirect education efforts, and a summary of financial expenditures for the Food Stamp Nutrition Education services.
- **On-line outreach reporting system—**This new reporting system will allow community partners to report outreach performance numbers directly to the state office.
- **On-line community-based outreach resource website—**This website will allow outreach partners to order materials, access policy updates, and request trainings, and it will provide a community calendar of events that can be shared among programs to increase collaboration among HHSC programs.

Healthy Marriage Program

Target Population

The Healthy Marriage Program (HMP) serves teenagers, engaged and committed couples, married couples, singles, newly expectant parents who are unmarried, low-income individuals and families, and clients of Head Start, Early Head Start, and DARS' Child Protective Services (CPS).

Service Description

The goal of HMP is to increase the well-being of Texas children by providing marriage and relationship education to their parents. HMP accomplishes this goal through a partnership of public, private, community, and faith-based organizations and leaders who work together to build awareness, provide relationship training and support, and participate in research to improve existing programs and policies.

In FY 2007, there are 17 contracts for healthy marriage projects. In FY 2008, there are 28 contracts for healthy marriage projects. HMP anticipates that its 12 Regional Intermediaries (RIs) will select 72 subcontracted providers through competitive procurement for healthy marriage services. The program contracts and partners with public, private, community, and faith-based organizations to provide services and to operate its 11 program components. The following is a list of the federal grants and program components under Healthy Marriage:

- Building Strong Families,
- Community Healthy Marriage Initiatives,
- Demonstration Projects that improve child well-being by fostering healthy marriages within underserved communities,
- Healthy Marriage Development Program,
- Post-Adoptive Marriage Enrichment,
- Supporting Healthy Marriages,
- Domestic violence technical assistance in relationship to healthy marriages,
- Healthy marriages technical assistance,
- Texas Research Advisory Group,
- Twogether in Texas, and
- Twogether in Texas Web Registry.

In Twogether in Texas, RIs promote the statewide implementation of healthy relationships and child well-being in Texas.

Trends and Initiatives

In the 80th Legislature, Regular Session, 2007, two bills were passed regarding healthy marriages. H.B. 2683, 80th Legislature, Regular Session, 2007, approved spending $15 million in federal TANF funds for HHSC to administer a grant program that supports the development of healthy marriages and the strengthening of families. H.B. 2683 became effective on September 1, 2007.

H.B. 2685, 80th Legislature, Regular Session, 2007, allows a couple who attends an eight-hour premarital course to forego the 72-hour waiting period after applying for a marriage license, and it eliminates the $60 marriage license fee. HHSC received an additional $1 million in TANF funds to maintain a website to register trained marriage educators, make information available to the public, and verify that premarital

education courses meet requirements to be skills-based and researched-based. H.B. 2685 becomes effective statewide September 1, 2008.

To support these legislative directives, HHSC is developing a network of providers, led by 12 RIs, to create statewide capacity for premarital and marriage education services. RIs will build and manage a service delivery network in their region by subcontracting with local providers and identifying a base of volunteers. This strategy encourages existing providers to connect with the RIs and enables grassroots organizations to deliver services throughout the region with local oversight by the RI.

Most of the healthy marriage curricula teach and develop skills in communication, relationship nurturing, and conflict management. Although presented in the context of a couple's relationship, these same skills are applicable to parenting as well. Most of HMP contractors are agencies that offer an array of family services that include parenting skills. If a parent wants to acquire more parenting skills, a referral can be made to a parenting program in that agency or to parenting programs available in the community.

Community Resource Coordination Groups of Texas

Target Population

Community Resource Coordination Groups (CRCGs) originated with S.B. 298, 70th Legislature, Regular Session, 1987. This bill directed state agencies serving children to develop a community-based approach to improve coordination of services for children and youth who have multi-agency needs and require interagency coordination. All areas of Texas have a CRCG for children and youth. S.B. 1468, 77th Legislature, Regular Session, 2001, broadened the charge to include the adult population. Accordingly, communities have begun using the county-based CRCG approach to serve adults with complex needs whose needs would not otherwise not be met. Some communities are adding the capacity to serve adults by expanding the current CRCG for children and youth, thus becoming a CRCG for families. Other communities have chosen to develop a separate group to serve adults. Organized by counties, some CRCGs cover several counties to form one collective CRCG, while others are single-county CRCGs.

CRCGs serving adults receive referrals from private sector organizations, local MHMR Centers, Adult Protective Services, other parties, and the local area agencies on aging. CRCGs serving children and youth receive referrals from a variety of locations, including local school districts, juvenile probation departments, local MHMR centers, families, and CPS. Mental health care is the most frequently identified service need for children and youth referred to local CRCGs. During 2006, approximately 63 percent of the children and youth served by CRCGs were at risk of being removed from their homes due to the need for behavioral health intervention. HHSC provides oversight to the Texas Integrated Funding Initiative to enhance local child-serving mental health systems through demonstration of a System of Care

service delivery approach in local communities and through recommendations from a consortium of state agency stakeholders and an equal number of family and youth representatives.

Service Description

CRCGs help people whose needs cannot be met by a single agency. HHSC provides state level coordination of CRCGs. Composed of a variety of public and private agencies in an area, CRCGs provide a way for individuals, families, and service providers to prepare an action plan to address complex needs of HHS System consumers. The groups can include representation from the HHS System agencies, the criminal or juvenile justice system, the education system, housing agencies, the workforce system, local service providers, and families.

More than 160 CRCGs exist. CRCGs are available to serve children and youth in all 254 Texas counties, and a growing number of CRCGs are available to serve adults. Local CRCGs use no federal or state dedicated funding but rely on agency or organization resources. Some CRCGs have obtained outside funding to support their collective efforts, to obtain a dedicated service coordinator position, or to secure flexible funding for services.

HHSC Goal 7: Office of Inspector General

HHSC will leverage technology and collaborative partnerships to protect the integrity and ensure accountability in the delivery of health and human services in Texas.

Target Population

The OIG serves the state of Texas by improving the integrity, efficiency, and effectiveness of the HHS System.

Service Description

The OIG, authorized by Section 531.102 of the Government Code, provides program oversight of HHS System activities, providers, and recipients through its compliance, enforcement, and chief counsel divisions, with the goal of improving the integrity, efficiency, and effectiveness of the HHS System. OIG fulfills its responsibility through the following activities:

- Auditing the use and effectiveness of state and federal funds, including the use of funds by contractors and grantees;
- Researching, detecting, and identifying patterns or incidents of waste, fraud, and abuse;
- Conducting investigations and reviews, and monitoring cases;
- Recommending policies that help prevent and detect waste, fraud, or abuse;

- Providing education, technical assistance, and staff training to improve quality of care, promote cost avoidance, and improve relationships with providers;
- Referring matters to outside agencies for further action when appropriate; and
- Instituting sanctions and performing corrective actions against program providers and clients when appropriate.

The OIG was created by H.B. 2292 as an independent office responsible for preventing and investigating waste, fraud, and abuse in the HHS System and reducing inappropriate program expenditures.

The Governor's Executive Order RP 36 (dated July 12, 2004) directed all state agencies and specifically HHSC to aggressively target waste, fraud, and abuse and to focus efforts toward reducing inappropriate or unjustified program expenditures. Executive Order RP 36 directed each state agency to comply with specific initiatives and directives to prevent, detect, and eliminate waste, fraud, and abuse in state government and to develop a fraud prevention program. The executive order outlined risk assessment tools to help agencies determine vulnerabilities; best practices that eliminate fraud in contracting, contract management and procurement; and common components for fraud prevention and elimination programs. HHSC continues to report its compliance with this executive order to the Governor's Office and to recommend statutory changes to improve fraud prevention and elimination.

OIG will also continue to work with other HHS System agencies and divisions to foster coordinated proactive measures and to recommend policies that enhance fraud prevention efforts. For example, when Medicaid/CHIP contracted for Vendor Drug Program (VDP) claims processing, OIG worked with them to include the requirement for a Cost Avoidance Project for VDP claims. Historically, Texas used a payment recovery, or "pay and chase" approach, for the VDP. Implementing a cost avoidance program in addition to payment recovery is expected to further increase savings for the program. Further, OIG worked closely with both Medicaid/CHIP and the Rates Analysis Division to implement policy changes for outpatient rehabilitation facilities and comprehensive outpatient rehabilitation facilities. Reimbursement for these providers changed from a cost-report reimbursement methodology to a prospective payment system based on established fee schedules. This policy change prevents overpayments resulting from inclusion of large, unallowable costs in the prior cost-report methodology.

Trends and Initiatives

Advancing the HHS System mission and the Governor's Executive Order RP 36, OIG initiates proactive measures and deploys advanced information technology systems to aggressively reduce, pursue, and recover expenditures that are not medically necessary or justified. Listed below are some of the measures and systems in use:

- **Diagnosis-Related Groups Validation Project**—A vendor contracts to review a subset of hospital inpatient claims to validate diagnosis assignments so billing errors may be identified and erroneous payments recovered.
- **Medicaid Fraud & Abuse Detection System** — An automated system that employs neural network technology to detect fraud, abuse and waste and, thereby, directly supports OIG's mission to efficiently and effectively identify potential fraud, abuse and waste in the Texas Medicaid Program.
- **TeamMate**—Auditing software uses a relational database engine that enables users to quickly access information of interest.
- **"i2"**—Investigative software allows users to quickly develop and recognize patterns of collusion and fraud through relational and analytical methodologies.
- **Computerized Data-Matching**—Cooperative data-matching initiatives are conducted with various federal and state law enforcement organizations including the Federal Bureau of Investigation, SSA, DPS, and the National Center for Missing and Exploited Children.

HHSC Internal Assessment

The consolidation five years ago of 12 independent health and human services agencies into a coordinated system of five agencies has resulted in a robust and adaptable foundation to meet the continuing challenges of delivering health and human services to Texans in need. As the agency assigned oversight for the enterprise, HHSC has used this foundation to focus and prioritize the work of the HHS Enterprise agencies on providing for client needs and program services delivery, being effective stewards of public resources entrusted to our program and administrative services, and establishing a culture of transparency and accountability. The broad array of health and human services programs, the changing economic climate, shifting demographics, changes in federal funding requirements and other significant factors noted in this strategic plan provide continuing challenges for the enterprise. The foundation laid by the consolidation, and the dedication of the leadership and staff across the enterprise, continue to be major assets in our transformative efforts.

HHSC continues to meet its mandated responsibility for providing administrative and support services for the enterprise agencies, whether consolidated at HHSC or coordinated across agencies. Most support services have been in place long enough to gain the experience necessary for a methodical and systematic reappraisal of their business processes in relation to agency needs. These reappraisals include reassessing and refining performance measures as well as evaluating decision-making processes. This re-examination is likely to uncover opportunities for various administrative and support services to better ensure good stewardship of resources and enhance accountability through rational realignment of

business processes that have been in place at agencies since before the consolidation. Some changes may have a varying impact across agencies as a result of the extent to which their current business processes differ from what is now needed across the Enterprise. The experience gained trough the consolidation and transformation efforts to date will be a major asset in ensuring these ongoing efforts continue successfully.

The continuing progress of the Medicaid and CHIP programs are good examples of the power of the "Enterprise model" to facilitate integration and optimization in improving service delivery to Texans in need. HHSC is better able to coordinate and align all Medicaid activities across the HHS System agencies to ensure consistency, identify gaps, and increase efficiencies. This enhanced coordination allows HHSC to identify and implement significant improvements in program and contract management. More importantly, it provides a platform for modernizing the service delivery system to take advantage of the efficiencies that technology can provide both in data management and in opening up portals for clients to access services. This coordination has also allowed HHSC to bring the best and brightest Enterprise talent to bear on developing innovations to enhance Texas' ability to efficiently and effectively manage the costs of meeting the health needs of Texans. This comprehensive and far-reaching transformation is not without its challenges and HHSC continues to work to find ways to help staff and stakeholders adjust while carefully and deliberately pursuing the optimization of client services.

Knowledgeable and dedicated leadership and staff, the experience gained from consolidation, and a robust and adaptable Enterprise-wide foundation are key pillars for continuing success in optimizing health and human services delivery for Texans in need. There will be additional challenges both in transforming the Enterprise and in addressing the larger, ever changing conditions of our environment. HHSC remains committed to providing the leadership, guidance and oversight to successfully meet these challenges.

Chapter VI

Department of Aging and Disability Services External/Internal Assessment

The Department of Aging and Disability Services (DADS) was established by House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, and became operational in September 2004. As mandated by this bill, DADS provides a continuum of long-term services and supports that are available to eligible older Texans and individuals with physical disabilities and intellectual and developmental disabilities. To safeguard the health and safety of individuals receiving long-term services and supports from providers, DADS licenses and regulates providers of these services. Later, Senate Bill (S.B.) 6, 79th Legislature, Regular Session, 2005, transferred the Guardianship Services Program from the Department of Family and Protective Services (DFPS) to DADS, effective September 1, 2005. This transfer of program authority resulted from one of the recommendations of a study of Adult Protective Services (APS) reform conducted by the Health and Human Services Commission (HHSC) in 2004 in response to an executive order from Governor Perry.

Through its mission of providing a comprehensive array of aging and disability services and supports that are easily accessed in local communities, DADS works to achieve its vision to support older Texans and persons with disabilities with a comprehensive and cost-effective service delivery system that promotes and enhances individual well-being, dignity, and choice.

The biennial strategic planning process within the Health and Human Services (HHS) Enterprise (or System) provides DADS with the opportunity to assess the external and internal trends and challenges affecting the provision and regulation of long-term services and supports. Informed by DADS internal and external stakeholders, this assessment has identified challenges, trends, and opportunities, emerging from external circumstances and DADS daily internal operations and the actions DADS is taking to address them.

The material in this chapter is arranged as follows:

- Challenges and Opportunities;
- Current Activities by Goal:
    - Target Populations and Service Descriptions,
    - Trends and Challenges, and

    - Initiatives; and
- Internal Assessment.

Challenges and Opportunities

Medicaid Waiver Programs

Medicaid waiver programs offer individuals services and supports in the community to assist them in maintaining their independence and to prevent institutionalization. However, the number of individuals requesting these community-based services continues to grow at a rate that exceeds the funding available to provide the services. To accommodate this, DADS maintains a list of individuals who are interested in receiving services, when the services become available. If a person or their family member is interested in having their name placed on one of these lists, they are encouraged to contact a DADS case manager or intake staff with their local MRA.[*] In an effort to reduce the number of individuals whose names are on these lists, DADS received funding from the 79th and the 80th Legislatures. These funds were used to authorize the enrollment of 4,993 additional individuals into the Medicaid waiver programs during the 2008-09 biennium.

Regulatory Services

The Department's Regulatory Services Division is responsible for the licensing, inspection, and enforcement of long-term care facilities and agencies. These regulatory activities enable DADS to ensure that individuals receive appropriate care and services and are protected from abuse, neglect, and exploitation. The primary challenge faced by DADS in the provision of regulatory services is recruiting and maintaining a qualified workforce to carry out its regulatory responsibilities.

While DADS has taken various actions to recruit and retain qualified staff, several factors impede progress in this area. Impediments include the inability to compete with salaries in the private sector, a national shortage of nurses, and demanding work requirements that include extensive travel. Efforts to support recruitment and retention include raising the base salaries of some surveyor job classifications, increased flexibility in work schedules, and improved organizational communication. Through continued focus on recruitment and retention efforts, DADS' turnover rate has begun to decline. In addition, as the number of licensed home and community support services agencies grows, DADS will need to have sufficient qualified staff to

[*] For two of the waiver programs, the CLASS and the DBMD, individuals may call a DADS toll-free number for placement on the list.

license, regulate, and monitor the increasing number of licensed agencies and the services provided to vulnerable populations.

Challenges to ensuring the health and safety of nursing facility (NF) residents include gauging the financial health of NF applicants prior to determining whether to grant licensure/certification and monitoring the ongoing financial health of NF license holders. To address this challenge, DADS has developed a system to obtain and analyze financial information from NF providers initially, during a change of ownership, and on an ongoing basis in accordance with Texas Health and Safety Code Sections 242.032(c), 242.032(e), and 242.074.

State Mental Retardation Facilities

State mental retardation facilities (state schools and state centers) are part of the Texas mental retardation service delivery system. There are 11 state schools and two state centers certified as intermediate care facilities for persons with mental retardation (ICFs/MR). These facilities provide 24-hour services in a residential setting that are responsive to individuals' needs and preferences. The average enrollment for FY 2007 was 4,909 individuals. The primary challenges for state mental retardation facilities are:

- Maintenance of physical structures,
- Age of transportation vehicles,
- Cost of pharmaceuticals and utilities,
- Continued support for non-certified beds in locked homes with pure general revenue (GR) funds, and
- Recruitment and retention of well-trained and qualified staff.

The physical structures of state mental retardation facilities are aging rapidly and are in need of repair and renovation. Needs to be addressed include the replacement or renovation of capital items such as roofs, bedrooms, living rooms, and other areas for use by individuals who receive services from state mental retardation facilities. To address these maintenance needs, DADS received $39.8 million in general obligation bonds in fiscal year (FY) 2008 for repairs and renovations to the physical structures to continue to maintain compliance with the Life Safety Code. Future investments in the maintenance and renovation of state mental retardation facilities/centers will allow DADS to continue to provide a safe and home-like residential setting for those who choose these services and supports.

The state mental retardation facilities use 864 vehicles. These vehicles provide transportation for and support of nearly 5,000 individuals with various levels of disability. Transportation is provided to community settings for daily life needs and for visits to community living options. Transportation is provided on campus for training purposes, medical needs, work, and attending chapel. These vehicles also provide transportation of laundry, medications, meals, maintenance materials

equipment and crews, and housekeeping equipment and crews to support residential services.

These transportation and support services vehicles are aging rapidly and are in need of replacement. During the 2006-07 biennium, DADS received funding to replace approximately 117 consumer transportation vehicles. The Department did not receive funds to replace support vehicles such as laundry, food services, and maintenance vehicles. For the 2008-09 biennium, DADS received funds to replace an additional 24 vehicles. Future investments in vehicles will allow DADS to continue efforts to help ensure the safe transportation and continued operations of state mental retardation facilities.

State mental retardation facilities continue to experience increasing costs for pharmaceuticals and utilities. For pharmaceuticals, the state mental retardation facilities have experienced a yearly average cost increase of approximately 13 percent since FY 2003. The projected increase for electric and natural gas utility costs is approximately six percent annually during the 2008-09 biennium. Future investments in pharmaceuticals and utilities will allow DADS to keep pace with inflationary challenges.

Mexia State School has a special program developed to address the significant behavioral needs of individuals admitted under the Code of Criminal Procedure and the Family Code as not competent to stand trial due to mental retardation. The program also serves consumers who are admitted under the Persons with Mental Retardation Act without legal system involvement, who have similar needs. The program includes 40 non-certified beds in locked homes, which cannot receive Medicaid ICF/MR funding. The locked homes ensure the safety of other residents, school employees, the surrounding community, and families during home visits. GR funds services provided by this specialized program. The amount of GR spent to cover non-certified ICF/MR beds due to locked homes at Mexia for FY 2007 was approximately $5.8 million. Continuing investment of GR funds will allow DADS to continue to support the needs of individuals receiving services through this special program.

State mental retardation facilities continue to face challenges in recruiting and retaining a qualified and stable workforce due to the lack of competitive salaries and benefits, an aging workforce, low enrollment in nursing schools, and the stress of working long hours with individuals with intensive medical and behavioral needs. This workforce includes qualified direct care staff, qualified mental retardation professionals, registered therapists, licensed vocational nurses, registered nurses, pharmacists, psychiatrists, and physicians. This workforce is critical to meeting the needs of individuals who live in and receive services and supports from state mental retardation facilities.

The Department received funding through the 2008-09 General Appropriations Act (Article II, Department of Aging and Disability Services, H.B. 1, 80th Legislature,

Regular Session, 2007), to increase the number of positions at state facilities. The Department's recruitment efforts have included an increased use of local and national advertisements, participation in career fairs at colleges and universities, and increased collaboration with professional health care organizations. Continued investment in recruitment and retention of a well-trained and qualified workforce will facilitate meeting the needs of persons who live in and receive services and supports from state mental retardation facilities.

Current Activities by Goal: Target Populations and Service Descriptions, Trends and Challenges, and Initiatives

DADS Goal 1: Long-Term Services and Supports

To enable older and disabled Texans to live dignified, independent, and productive lives in a safe living environment through an accessible, locally-based, comprehensive and coordinated continuum of services and opportunities, to provide appropriate services and supports based on individual needs ranging from in-home and community-based services for elderly people and people with disabilities who request assistance in maintaining their independence and increasing their quality of life, to institutional services for those who require that level of support, seeking to ensure health and safety and to maintain maximum independence for the individual while providing the services and supports required.

Target Populations and Service Descriptions

Community-Based Services[†]

The Department provides an array of community-based services made available through Medicaid entitlements, Medicaid waiver services, the Older Americans Act (OAA), Social Services Block Grant funds, or GR appropriations.

Medicaid community-based, entitlement services include Community Attendant Services (CAS), Day Activity and Health Services (DAHS), and Primary Home Care (PHC). An entitlement program means that the state must provide those services to all individuals who request such services and are eligible.

In FY 2007, the average number of individuals per month receiving Medicaid community-based entitlement services by program was as follows:

[†] All figures for the average number of individuals per month receiving community-bases services do not include STAR+PLUS managed care, which is managed by HHSC, or the ICM waiver program that began on February 1, 2008.

- CAS – 42,089;
- DAHS – 17,349; and
- PHC – 59,065.

While program eligibility criteria for waiver programs are similar to those for institutional programs, the federal government allows states to waive certain requirements (e.g., comparability, eligibility, and statewide availability) and limit the number of individuals served. Medicaid waiver programs are dependent on specific state and federal appropriations. Typically, an individual will be placed on a waiver interest list because the demand for services is greater than the number of available program slots.

The Medicaid waiver programs are as follows:

- Community-Based Alternatives (CBA),
- Community Living Assistance and Support Services (CLASS),
- Consolidated Waiver Program (CWP),
- Deaf-Blind with Multiple Disabilities (DBMD),
- Home and Community-Based Services (HCS),
- Medically Dependant Children Program (MDCP), and
- Texas Home Living (TxHmL).

Integrated Care Management (ICM), the newest waiver program, began February 1, 2008. This waiver program is a non-capitated primary care case management model of Medicaid managed care. The program is available in the Dallas and Tarrant service areas. HHSC's ICM program began enrolling participants in December 2007 and January 2008. Participants began receiving services through the program on February 1, 2008.

In FY 2007 the average number of individuals per month receiving services through Medicaid waivers by program was as follows:

- CBA – 26,783;
- CLASS – 3,113;
- CWP – 182;
- DBMD – 138;
- HCS – 11,796;
- MDCP – 1,508; and
- TxHmL – 1,392.

Services funded through the Social Security Block Grant include Adult Foster Care, Consumer Managed Personal Attendant Services, DAHS, Emergency Response, Family Care, Home Delivered Meals, Residential Care, and Special Services for Persons with Disabilities. Services funded through GR include In-Home and Family

Support Services. Services funded through Medicaid include the Medicaid Hospice Program and the Program for All-Inclusive Care for the Elderly (PACE).

In FY 2007, the average number of individuals per month receiving other regional and local community-based services, which were funded through the Social Security Block Grant, was as follows:

- Adult Foster Care – 124;
- Consumer Managed Personal Attendant Services – 500;
- DAHS – 1,296;
- Emergency Response – 17,753;
- Family Care – 6,427;
- Home Delivered Meals – 16,522;
- Residential Care – 611; and
- Special Services for Persons with Disabilities – 134.

In FY 2007, the average number of individuals per month receiving other regional and local community-based services, which were funded through GR, was 3,914.

In FY 2007, the average numbers of individuals per month receiving other regional and local community-based services, which were funded through Medicaid, were as follows:

- Medicaid Hospice Program – 548,[‡] and
- PACE – 914.

Aging Services under Older Americans Act

The Department is designated as the State Unit on Aging and is responsible for administering the OAA programs for individuals who are 60 years of age or older. The 28 Area Agencies on Aging (AAAs) in Texas provide three major types of services: access and assistance, nutrition, and supportive services, including services for informal caregivers. These services are generally provided for a short term while individual or family circumstances stabilize. Other resources are identified to meet the long-term service and support needs of individuals or their caregivers.

The eligibility requirements for services under the OAA are:

- To be 60 years of age or older, or to be a family member or caregiver seeking support on behalf of someone 60 years of age or older; or
- To be a family member or caregiver;

[‡] Note: In FY 2007, the Medicaid Hospice Program served an average of 6,026 individuals, of whom 548 individuals received hospice services in the community and 5,478 individuals received hospice services in NFs.

- 18 years of age or older caring for an individual 60 years of age or older;
- An individual of any age who has Alzheimer's disease and related disorders; or
- Who is a grandparent or relative caregiver, 55 years of age or older, providing care to children younger than 18 years of age or to adults from 18 to 59 years of age who have disabilities.

The Older Americans Act services and outreach activities are targeted to older individuals with the greatest social and economic need with particular attention to minority, older individuals with low incomes, older individuals with limited English proficiency, older individuals residing in rural areas, and older individuals at risk for institutional placement.

Mental Retardation Authority Services

The Department offers GR funded community-based services to individuals with diagnoses of intellectual and developmental disabilities who meet diagnostic and functional need criteria. Local MRAs serve as the point of entry for publicly funded mental retardation programs. The program may be provided by public or private entities. MRAs provide or contract to provide an array of services for persons with mental retardation, and are responsible for assisting individuals to apply for enrollment into the following Medicaid programs: ICF/MR, which includes state mental retardation facilities (state schools and state centers), HCS, and TxHmL.

Services available through a local MRA include:

- Eligibility determination,
- Service coordination,
- Respite,
- Community support,
- Day habilitation,
- Employment assistance,
- Supported employment,
- Vocational training,
- Specialized therapies,
- Behavioral support, and
- Nursing.

These services are funded through GR appropriations, with the exception of some service coordination services which receive funds from Medicaid. In FY 2007, MRAs across Texas served an average of 13,141 individuals per month, excluding waiver services.

Institutional Services

The Department oversees various types of facilities that provide long-term services and supports to older Texans and individuals with disabilities. The NFs provide services to individuals whose medical conditions require the skills of a licensed nurse on a regular basis. The ICFs/MR provides long-term services and supports for persons with mental retardation or related conditions requiring residential, medical, and habilitative services.

The NF Program provides services for medical, nursing, and psychosocial needs. These services include rehabilitative services, emergency dental services, and specialized services. In FY 2007 NFs served approximately 57,217 individuals per month through Medicaid. Also in FY 2007, an average of 6,495 individuals per month had their Medicare Skilled NF co-insurance paid by Medicaid.

The ICF/MR program provides ongoing evaluation and individual program planning, as well as 24-hour supervision, coordination, and integration of health or rehabilitative services to help individuals function to their greatest ability. These residential settings range in size from six beds to several hundred, such as state mental retardation facilities. In FY 2007, an average of 11,517 individuals per month received care from ICF/MR.

Guardianship Services

The Guardianship Program administered by DADS provides guardianship services to individuals referred by DFPS. The target population served by the Guardianship Program is defined by statute and is limited to the following two groups:

- Individuals 65 years of age or older or individuals with disabilities from 18 to 65 years of age, who have been identified by APS as victims of abuse, neglect, or exploitation and who have an indication of incapacity; and
- Individuals reaching 18 years of age who have been in a Child Protective Services (CPS) conservatorship and who are incapable of managing their own affairs due to incapacity.

The Department provides guardianship services either directly or through contracts with local guardianship programs. There are 84 regional guardianship employees housed in 25 offices throughout the state providing coverage of all 254 counties in Texas. The Department contracted with five local guardianship corporations in FY 2007, serving up to 220 individuals referred for guardianship services. In FY 2007, the Guardianship Program served an average of 1,045 individuals per month. Of these individuals, 187 were served by guardianship contractors and 858 by DADS local guardianship services.

DADS Goal 1 Trends and Challenges

Demographic Profile

Growing Population of People 60 Years of Age or Older

The first baby boomers turned 60 in 2006. In 2007, the number of Texans 60 years of age or older was an estimated 3.3 million. By 2010, this population is projected to grow to approximately 3.7 million. By 2030 the number of Texans 60 years of age or older will double to 7.5 million. By 2040 the same population is projected to grow to 9.4 million, comprising almost 25 percent of the Texas population.

Figure 6.1

Projected Texas Growth for the Population 60 Years of Age or Older, 2009-40 (Millions)

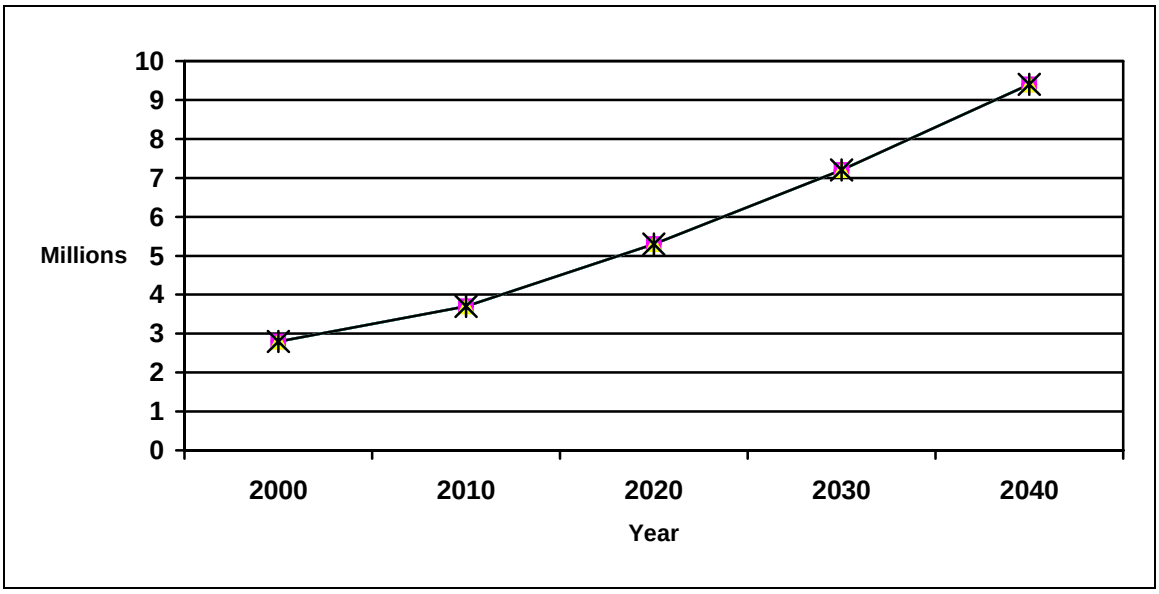


Figure 6.1: Texas State Data Center at the University of Texas at San Antonio. Population projections based on 2000-2004 migration.

Growing Population of People 85 Years of Age or Older

Among older individuals, those 85 years of age or older comprise the fastest growing population in Texas. In 2007, an estimated 238,000 individuals were 85 years of age or older. By 2010, this population is projected to grow to approximately 304,685. The first baby boomers will turn 85 in 2031. By 2040, this population is projected to be 924,136 individuals.

Figure 6.2
Projected Texas Growth for the Population 85 Years of Age or Older, 2009-40

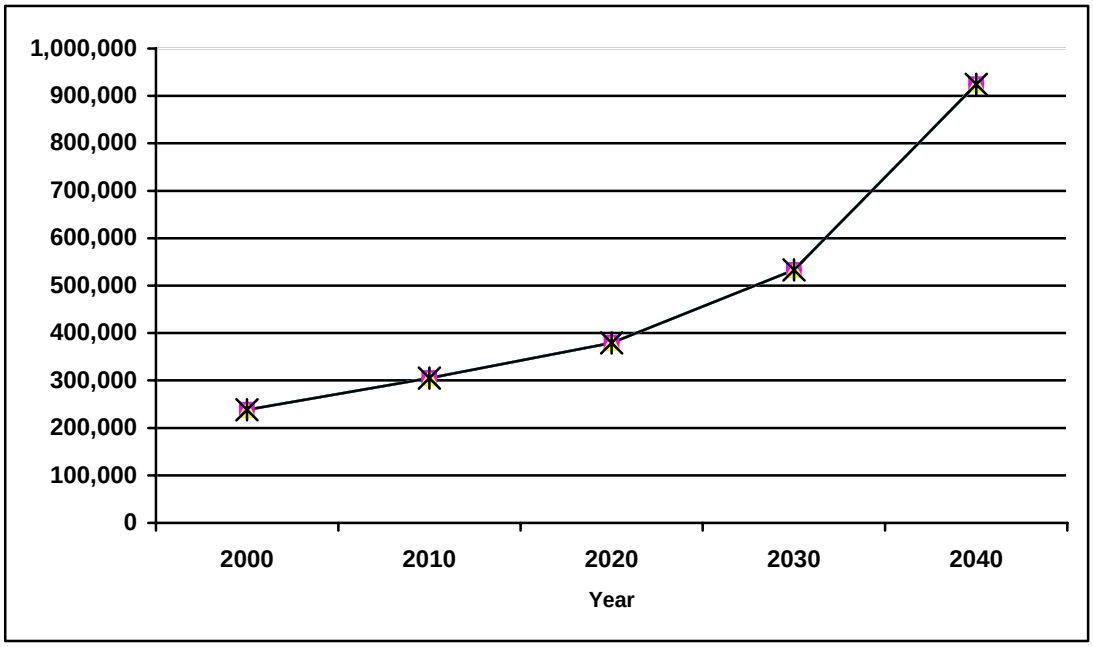


Figure 6.2: Texas State Data Center at the University of Texas at San Antonio. Population projections based on 2000-2004 migration.

Growing Ethnic Diversity

Patterns of rapid growth exist among both younger non-Anglo ethnic groups and the older Anglo population. However, Texas also has the second largest older Hispanic population in the country, with this population expected to double from 2007-2040. These growth patterns suggest that individuals who are non-Anglo will become increasingly central to future population trends in Texas. The percentage of non-Anglo older Texans is projected to increase from 31 percent in 2005 to 62 percent in 2040, creating a need to ensure that services, outreach tools, and enrollment processes remain culturally appropriate to the entire population.

Figure 6.3 illustrates how the older Hispanic population is expected to outpace that of Anglos and African-Americans from 2007-40. In 2007, the Anglo population was 68 percent of the total population of people 60 years of age or older. By 2040, that number is expected to drop to 37 percent. In 2007, African Americans constituted nine percent of the population 60 years of age or older, a figure expected to change little by 2040. However, the Hispanic portion of the 60 years of age or older population, which was 20 percent in 2007, is expected to increase to 41 percent by 2040. All other population groups combined, in the 60 years of age or older population, are expected to increase from three percent to 14 percent between 2007 and 2040.

Figure 6.3
Projected Growth in Texas for the Population 60 Years of Age or Older, by Ethnicity, Years 2007-40

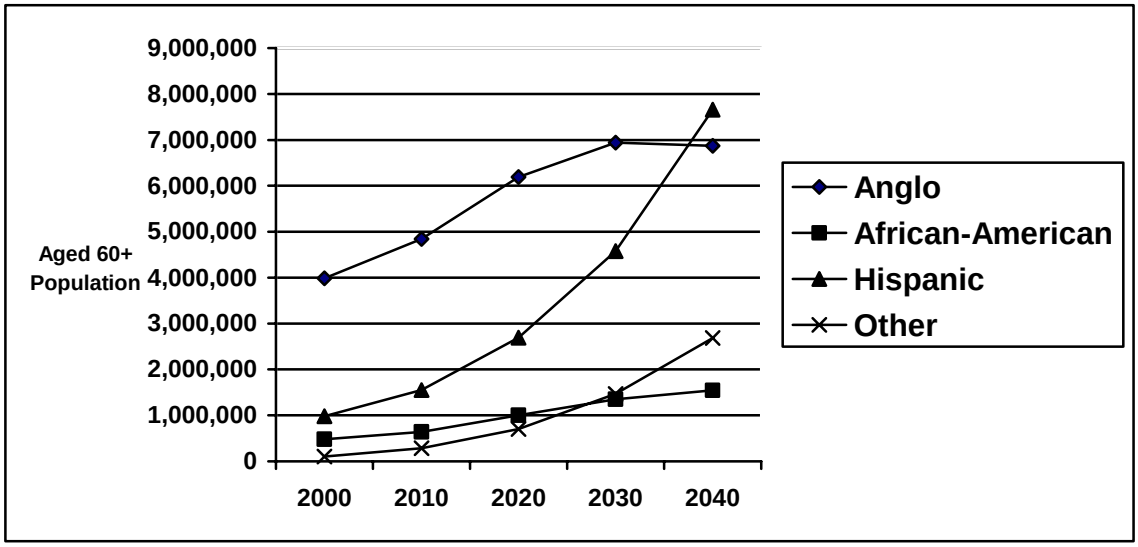


Figure 6.3: Texas State Data Center at the University of Texas at San Antonio. Population projections based on 2000-2004 migration.

Rural vs. Urban Population

Population growth varies across the different regions of Texas. Most growth is projected to occur in and around urban areas. However, the more rural and isolated areas present particular challenges for the delivery of health and human services. Rural communities may develop an increasing proportion of older residents as younger residents move away. As an increased number of Texans reach 60 years of age, a more targeted focus on providing services to those at greatest risk or need who reside in rural communities will be necessary.

Increasing Prevalence of Disabilities by Age Group

Approximately 1,232,000, nearly 40 percent, of Texans 60 years of age or older have a disability. The most common type of disability, 77 percent of the total, reported by older adults is physical disability. This drastically affects an individual's mobility, ability to conduct activities of daily living, and overall quality of life. Figure 6.4 shows the portion of the Texas population 60 years of age or older with disabilities. The rate of disability increases as people age.

Figure 6.4
Percent of Texans 60 Years of Age or Older Who Have a Disability, by Age Group, 2005

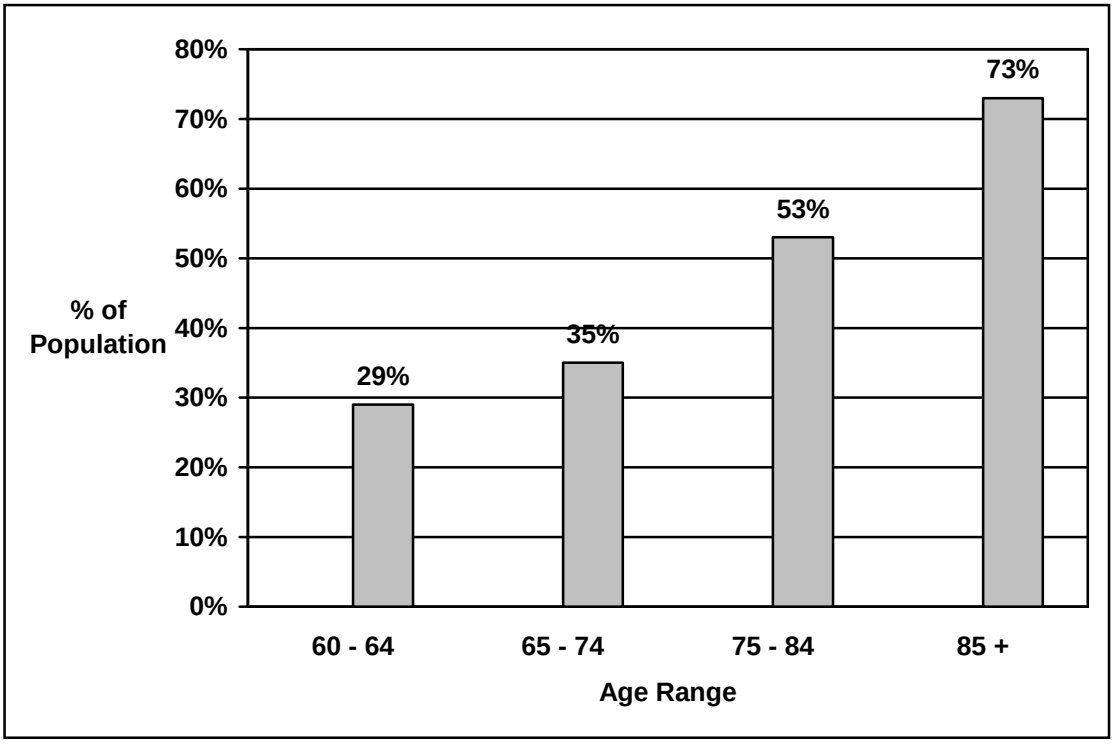


Figure 6.4: ***Partnership for Solutions. Chronic Conditions: Making the Case for Ongoing Care*****. Baltimore, MD., Johns Hopkins University, 2006.**

With continued advances in medicine and health care delivery, it is anticipated that there will be an increasing number of individuals with disabilities who survive and enjoy longer lives. The population of older Texans with a disability is expected to be more diverse than in previous generations. Among older Texans, African Americans have the highest rates of disability (52 percent), followed by Hispanics (47 percent), Anglos (36 percent), and other racial/ethnic groups (35 percent). Older women report a disability rate of 42 percent, as compared to 37 percent for older men, according to the 2006 Chronic Conditions Report by John Hopkins University.

Increasing Demand for Services

Stress on Informal Caregivers

Current estimates indicate that 25 percent of American families provide care to older adults, according to the 2004 Family Caregiver Support Report from the Family Caregiver Alliance. This informal system of care giving has been valued at $257 billion annually, more than double the national expenditure for NF and paid home care combined. This informal system is experiencing increased stress as the pool of

family caregivers shrinks. In 1990, there were 11 potential caregivers for each individual needing care, as reported in Care giving Statistics from the National Family Caregivers Association in 2006. By 2050, the expectation is for this ratio to fall to four to one.

Among people needing help with daily activities, 65 percent depend solely on family and friends, while an additional 30 percent supplement family care with services from paid providers, as reported on the DADS Aging Texas Well (ATW) website (http://www.agingtexaswell.org/caregiving). Only five percent rely exclusively on paid services such as those provided by assisted living facilities (ALFs) or NFs. If the work of caregivers had to be replaced by paid home care workers, the estimated national costs would be $45-$94 billion per year.

In addition, the DADS ATW website indicates that approximately 64 percent of caregivers are employed full-time or part-time. Although the exact number of workers who provide care to family members is not known, workplace surveys estimate that 13 percent of the workforce is caregivers. Care giving ultimately affects both the employee and the employer.

Because many employees take leaves of absence or stop working, either temporarily or permanently, to care for a loved one, employers find that care giving directly affects worker productivity, employee turnover, absenteeism, and early retirement. Caregivers often underestimate the time required for care giving and the impact of their obligations on their work. Estimates show an employee can lose as much as $660,000 in lost income, pensions, wages, and Social Security throughout their career. Many caregivers make informal adjustments to their work schedules that include telephone calls, taking time off during the workday, making up work on the weekend, or arriving early and leaving late. A MetLife Study of Employer Costs for Working Caregivers valued annual lost productivity at between $11.4 billion and $29 billion.

Continuing Demand for Home and Community-Based Services

Additional resources have supported the expansion in availability of waivers over the past several years. However, even with this expansion, the population requesting community services continues to increase, as the public's awareness of these services grows. This includes the demand for Medicaid services, as well as services for those without Medicaid or other insurance.

Although there have been significant additions to the resources available for waiver programs over the past several years, the number of individuals added to the interest list for HCS has increased at a rate that exceeds the rate of waiver growth. It is projected that by FY 2010 more than 40,000 individuals will be on the interest list for HCS funded services.

GR services provided by the Community Mental Health and Mental Retardation (MHMR) Centers allow for individuals who are not eligible for Medicaid, but who are

in need, to receive these critical services. Additionally, individuals who are waiting for HCS services also take advantage of these GR services while they are waiting for an HCS waiver slot. Approximately 35 percent of individuals on the HCS interest list receive other services through DADS. Therefore, it continues to be a funding and resource need that these services continue in order to provide the safety net for those individuals not eligible for Medicaid services and essential assistance such as respite or in-home family support, for these waiting.

Continuing Needs of Individuals "Aging Out" of Children's Disability Services

Many children with severe disabilities are living longer. The Comprehensive Care Program (CCP) Services provide all medically necessary services to children younger than 21 years of age who receive Medicaid. As children with disabilities age out of CCP Services, their continued care in the community through the CBA Waiver Program can exceed the allowable cost limit in a community-based Medicaid waiver program that would otherwise be available to the individual, making them ineligible for the program.

The 2008-09 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 45, H.B. 1, 80th Legislature, Regular Session, 2007) increases the cost limits for these individuals for six of the Medicaid 1915 (c) waiver programs administered by DADS. The rider also authorizes DADS to use GR funds for individuals who cannot be served safely in an institutional setting and whose needs exceed the waiver cost limits. In addition, the rider directs the agency to implement utilization management and review practices to ensure individuals receive the appropriate level of services, while maintaining compliance with the Center for Medicare and Medicaid Services (CMS) cost effectiveness requirements.

Continuing Interest in Consumer Directed Service Options

There is a growing interest by DADS consumers in having more control of their services and the attendants who perform those services. In Consumer Directed Services (CDS), the consumer has the ability to hire, fire, train, and supervise staff, as well as directly purchase services. Consumer direction of services is a component of a philosophy called self-determination.

In response to S.B. 1586, 76th Legislature, Regular Session, 1999, the CDS option was implemented in September 2001 in multiple Medicaid home and community-based waiver and entitlement programs including CBA, CLASS, DBMD, PHC, Consumer Managed Personal Assistance Services, and MDCP.
During the past seven years, CDS has steadily expanded. In February 2008, the CDS option became available in the HCS, TxHmL, and ICM waiver programs.

Growing Need for Services for Individuals with Disabilities and Co-Occurring Behavioral Health Needs

A growing need exists to provide services and supports to individuals with disabilities and co-occurring behavioral health conditions (mental health and substance abuse)

who desire to stay in their usual living environment. For example, HCS and TxHmL waiver providers have requested assistance with meeting challenges related to serving individuals with severe behavioral issues and other concerns. MRAs have observed that the lack of additional supports in these areas has resulted in the increased admission of individuals enrolled in those waivers to state mental health facilities. They have expressed concern that these types of admissions have resulted in increased usage of bed days being charged to community MHMR centers.

Services and supports, such as behavioral health support, crisis management, and counseling services, could address this need by allowing individuals to remain in their homes with appropriate treatment, avoiding repeated placements in state hospitals, NFs, and other institutions. In addition, these services and supports could have the effect of reducing admissions to state hospitals, but may require extensive resources and skills development in community programs.

Lack of Housing Options

In Texas a lack of integrated, accessible, and affordable housing exists for those with low incomes who are aging or who have disabilities and wish to live on their own, rather than with family or in residential facilities. Several factors contribute to this housing problem. There is not a formal relationship between Texas' housing financing agency, the Texas Department of Housing and Community Affairs, and the HHS Enterprise. Additionally, HUD funding goes directly to the state's 475 housing authorities, which makes facilitating individual housing needs more difficult. While there is money in the overall housing system, federal housing dollars are not dedicated for the Supplemental Security Income population who are aging, or who have disabilities and live in the community, or are trying to relocate back into a community residence. These individuals have to compete for dedicated federal housing vouchers with other needy populations (e.g. the homeless).

With continued federal direction for states to "rebalance" their long-term services and supports systems, as demonstrated through the "Money Follows the Person Rebalancing Demonstration" (Demonstration) mandated by Congress through the Deficit Reduction Act of 2005 (DRA), there will be more individuals residing in NFs with complex medical/functional needs who will be relocating to the community. A barrier to this relocation is the lack of access to integrated and affordable housing.

Increasing Demand for Guardianship Services

The demand for guardianship services is growing as the average age of the general population increases. The number of individuals served by the DADS Guardianship Program has increased approximately 30 percent since the program was transferred from DFPS in 2005. A growing need exists to reduce the number of individuals for whom DADS' employees provide guardianship services so these employees can focus on conducting more assessments and addressing the most difficult guardianship circumstances.

The 80th Legislature appropriated an additional $1,145,598 for the 2008-09 biennium for the expansion of local guardianship contracts. At the beginning of FY 2008, a request for proposals resulted in the addition of six new contracts with one existing provider and one new provider. Since December, 2004 the number of counties served by locally contracted guardianship providers increased from 29 to 57 counties with the newly procured contracts. The new local contracts, which became effective December 1, 2007, increased the potential number of individuals served by the local guardianship programs from 220 to 445.

Removing Barriers to Supported Employment

According to an October 2007 report by the National Council on Disabilities, the employment rate of individuals with disabilities is approximately half of the employment rate of individuals without disabilities. Over two-thirds of unemployed individuals with disabilities would prefer to be working. Although supported employment (SE) services are offered in many of DADS programs, overall utilization by DADS consumers is low. Historically, some factors contributing to low utilization include:

- Shortage of qualified SE providers,
- Small pool of available employers,
- Inconsistent coordination between the Department of Assistive and Rehabilitative Services (DARS) and DADS, and
- Barriers, such as lack of access to transportation.

With a greater percentage of consumers employed in competitive jobs, Texas businesses will achieve more diversity and a larger talent pool, and DADS will move closer to achieving its goal of maximum choice and freedom for consumers. Consumers will be more integrated into their communities, contribute to economic growth, and benefit from greater economic freedom and self-determination.

Provider Capacity and Infrastructure Needs

Increasing Provider Business Costs

The growing number of individuals receiving long-term services and supports requires an increased provider capacity and places increasing demands on provider infrastructure. Maintaining and expanding a healthy provider base will necessitate resources to support the increasing costs of doing business.

Providers incur increased costs as a result of the increase in the minimum wage, higher transportation and fuel costs for operations of provider vehicles transporting consumers, and heating and air conditioning costs for facilities serving consumers. Increased fuel costs also contribute to higher costs for food, laundry services, and costs of maintenance for facilities.

Increased operational costs resulting from the need to pay higher salaries and to train new staff in occupations with high turnover rates is another key factor in the increased cost of doing business. Finding and keeping trained personnel is important, not only when dealing with occupations with well-publicized shortages (e.g., nursing), but is also critical in other direct service worker (DSW) occupations.

Continuing Need for Qualified Direct Service Workforce

The Aspen Institute's publication, "Direct-Care Health Workers: The Unnecessary Crisis in Long-term Care" (2001), reported the direct service workforce plays a critical role in the home- and community-based system of services for older Americans and Americans with disabilities. DSWs provide an estimated 70 to 80 percent of the long-term services and supports to Americans who are aging or living with disabilities or other chronic conditions. Among other daily tasks, these workers help consumers bathe, dress, and eat. Some DSWs also help with housekeeping tasks, food preparation, and changing linens. They work with some of the most vulnerable members of the community, and the work is physically, mentally, and emotionally demanding.

Inadequate compensation, opportunities, and supports have made recruiting and retaining DSWs a critical workforce issue across the United States. In fact, the "2005 National Survey of State Initiatives on Long-Term Care Direct-Care Workforce" indicates that vacancies of DSWs continue to be a serious workforce issue for most states. Low wages, few benefits, part-time hours, poor supportive supervision, and lack of training, recognition, and respect have contributed to high DSW turnover rates in Texas and the United States. Job alternatives, including clerical or food-counter positions that are safer and less demanding than direct-care positions and which pay as well or better also contribute to DSW turnover. While Texas does not routinely collect statewide data regarding turnover of home health aides or personal and home care aides (e.g., attendants), the "2002 American Health Care Association Survey of Nursing Staff Vacancy and Turnover in Nursing Homes" reports the turnover rate of certified nursing assistants in Texas as 105.2 percent.

For providers, the direct cost of turnover (the costs of separation, vacancy, replacement, training, and increased worker injuries) is estimated to be at least $2,500 per separated employee. Turnover may also involve important indirect costs for providers, such as costs associated with lost productivity, reduced service quality, and deterioration in employee morale.

Increasing Need for Health Professionals

An adequate supply of health professionals, such as nurses, physicians, and pharmacists, ensures that providers, both private and public, have the capacity to meet the demand for long-term services and supports. Factors contributing to the shortage of health care professionals available to long-term services and supports providers include opportunities to earn higher salaries in other career options,

workload issues, decline in the number of qualified applicants seeking employment, and decline in the number of new students entering health professions, such as nursing. To address this shortage, there is a need to implement recruitment and retention strategies, including increased funding.

DADS Goal 1 Initiatives

The following initiatives represent DADS efforts to respond to the trends and challenges of Goal 1, Long-Term Services and Supports, identified in the previous sections. They correspond, in some nature, to the identified trends or challenges.

Supporting Individual Choice and Self-Determination

Promoting Independence, Choice, and Self-Determination

Several collaborative, interagency initiatives that DADS will be continuing or initiating involve HHSC and the other HHS System agencies that support individuals with disabilities living in the most integrated residential setting. These initiatives promote choice and self-determination.

Texas' Promoting Independence Initiative promotes public policies that enhance the ability of individuals with a disability to live in the most integrated residential setting. The statewide initiative began as a direct response to the United States Supreme Court decision in Olmstead vs. L.C. (June 1999).

One major systems change that resulted from this initiative is the "money follows the person" (MFP) policy which began on September 1, 2001, and was codified in statute effective September 1, 2005. This policy helps individuals who are receiving long-term services and supports in a NF return to the community to receive services without placement on a Medicaid waiver program interest list. In order to access the MFP policy, an individual must be a current NF resident and meet all the program eligibility criteria for the community-based waiver program. MFP has been very successful. Through December 31, 2007, more than 14,300 Texans have used the policy to relocate back to their communities to receive long-term services and supports.

The initiative also allows individuals in large community ICFs/MR (14 or more beds) or in state schools to have expedited access to the HCS waiver. Individuals in state schools may access an HCS slot within six months of referral, and those residing in a large community ICF/MR may access an HCS slot within 12 months of referral.

Texas MFP may receive up to $18 million in enhanced Medicaid funding through 2011 for a Texas MFP Demonstration. Texas was one of the original grantees to receive funding from the $1.8 billion national demonstration program that was included in the DRA as the MFP Rebalancing Demonstration.

The Texas MFP Demonstration will target 2,999 additional individuals who are current residents of the following institutions:

- NFs,
- Large ICFs/MR (14 or more beds),
- State mental retardation facilities (state schools), and
- Medium ICFs/MR (9-13 beds) whose providers want to close their facilities.

In addition to those populations currently served under the initiative, four specialized projects are part of the Demonstration.

- **Behavioral Health Pilot—**Individuals in Bexar County will be provided two new Demonstration services: Cognitive Adaptation Training and Adult Substance Abuse Training Services. The Department of State Health Services (DSHS) has the lead on this initiative.
- **Post-relocation contacts—**Relocation specialists will provide intensive post-relocation contacts with individuals to provide outside support and continuity with the relocation.
- **Overnight Companion Support Services—**Individuals in Cameron, Hidalgo, and Willacy Counties who have complex functional or medical needs will be able to hire an attendant during normal sleeping hours to be available for emergency situations and assistance with daily living activities, such as toileting.
- **Voluntary Closure of Nine or More Beds Community ICFs/MR—**Providers of these facilities will have an opportunity to work with DADS to voluntarily close their facilities and convert to a different business model. All residents of these facilities will be given freedom of choice on where they want to live in terms of community settings or another ICF/MR.

Community Living Options Information Process

The Community Living Options Information Process for adult residents in state mental retardation facilities was delegated to the MRAs by S.B. 27, 80th Legislature, Regular Session, 2007. This process assists consumers at state mental retardation facilities and their families in making informed choices about living options. Local MRA service coordinators share information about community options and provide opportunities for state school residents and their legally authorized representatives (LARs), if appropriate, to make visits in the community to get a first-hand look at community options and services. The two primary community programs available to state school residents who move to the community are the ICF/MR program and the HCS waiver program. This process ensures individuals and their LARs have comprehensive information and can make well-informed decisions on where and with whom they want to live. Individuals and their LARs are educated about the services and type of residential settings available through each program.

Expanding Consumer Directed Service Options to All DADS Waivers

As of February 1, 2008, DADS expanded the CDS option, which includes a new service, support consultation, to the TxHmL and HCS waivers. The CDS option also is available in the ICM waiver. Through the 2003 Real Choice Systems Change Grant under the New Freedom Initiative, DADS has piloted a hybrid service management option. This Service Responsibility Option (SRO) allows consumers to select, train, and supervise their attendants but leaves fiscal, personnel, and backup responsibilities with a provider agency. This option was developed to increase the opportunities for self-direction for those receiving PHC services, the majority of whom are elderly.

In preparation for expanding SRO statewide, staff worked with the HHS System's Rate Analysis to submit a state plan amendment (SPA) for support consultation, a requirement of SRO. Once the SPA is approved, statewide expansion of SRO in PHC and Medicaid managed care can begin. In addition, DADS' staff has developed a new Texas Administrative Code Chapter 43 which contains proposed rules for the SRO to be added to Chapter 41, CDS. In response to the 2008-09 General Appropriations Act (Article II, Special Provisions, Section 48, 80th Legislature, Regular Session, 2007), DADS' staff will update and distribute CDS educational material to all stakeholders and will provide ongoing training to case managers, service coordinators, and providers.

DADS hosted a series of town hall meetings across the state to provide an opportunity for individuals, service providers, and the general public to learn more about the CDS service delivery option available in many DADS programs. At each meeting, a panel of consumers or family members shared their experiences with the CDS option. Meetings were held in Weslaco, Fort Worth, Austin, Houston, and El Paso. Attendance at the town hall meetings ranged from 30 to 90 individuals, approximately half of whom were consumers or parents.

The Department's staff will continue to play an active role on the HHSC Consumer Direction Workgroup as required by S.B. 1766, 80th Legislature, Regular Session, 2007. The Department anticipates that consumers will experience greater satisfaction with services using the CDS model, compared with services that are agency-directed.

Waiver Standardization and Streamlining Initiative

Created under separate administrative authorities of different legacy health and human services agencies, at different times, and for different target populations, the Medicaid 1915 (c) waiver programs that DADS administers differ significantly in service delivery and administration. As the result of consolidation, DADS has begun re-examining these variations. Examples include differing:

- Level of Care and Medical Necessity processes,
- Adaptive aid authorization requirements, criteria, and exceptions,

- Individual Services Plans and Individual Program Plans, and
- Rate structures.

In reviewing these differences across the waivers, DADS has been working with stakeholders. They include internal stakeholders and external stakeholders who represent individuals and their families, advocacy groups, private providers, and provider associations.

Through the process of re-examining waiver delivery and administration, DADS' goal is to achieve standardization and increased efficiencies across the waiver programs. Achieving this goal will make it easier for DADS to manage and provide waiver services to individuals and make it easier for individuals to enroll and providers to deliver waiver services.

Improving Services to Individuals with Complex Needs (Including Behavioral Health)

Rider 45 and Hospital Level of Care Waiver

As provided by the 2008-09 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 45, H.B. 1, 80th Legislature, Regular Session, 2007), DADS has been authorized to use GR funds for individuals who cannot be served safely in an institutional setting and whose needs exceed the waiver cost limits. Rider 45 also increased the cost ceilings of the waivers. Serving large numbers of individuals with high costs in existing waivers could compromise cost neutrality of these waivers and reduce the number of individuals served. As a result, DADS is exploring the feasibility of a Hospital Level of Care (HLOC) waiver. This HLOC waiver would serve, in a community setting, individuals 21 years of age or older who have extensive nursing care needs and who would require frequent hospitalization. Serving individuals in the HLOC waiver could allow all costs to be matched, as opposed to using only GR, and could help protect the cost neutrality of DADS' other waivers.

Increasing Behavioral Health Training Opportunities for Providers and Staff

The Department facilitated a workgroup consisting of staff from DADS Regulatory Services, other DADS organizational divisions, and DSHS. Workgroup members reviewed data related to temporary discharges of individuals into psychiatric settings from HCS. Outcomes of extensive workgroup discussions, data collection and qualitative analysis, interviews with HCS providers, and information gathered from other states determined that coordination between HCS providers and psychiatric hospitals needed improvement. The providers indicated they would benefit from behavioral health training to address severe behavioral issues occurring with some individuals with intellectual and developmental disabilities and mental illness. The desired outcome of this training is to reduce the number of these individuals being admitted to a psychiatric facility or being incarcerated.

To address training needs, the DADS Regulatory Services division included behavioral supports training in its annual training for providers and surveyors in the summer of 2007 and plans to continue offering this topic at future trainings. In April 2008, the DADS Center for Policy and Innovation held a symposium on positive behavior management, providing specialized training for all DADS service providers. The target audience includes psychologists and board certified behavior analysts who develop behavior supports plans, provider staff responsible for oversight of behavior support plans, and direct service staff.

Autism Council – Autism Service Delivery Innovations Project

The Texas Council on Autism and Pervasive Developmental Disorders (Council) was established by legislation in 1987 that added Chapter 114 to the Human Resources Code. The governor-appointed Council is composed of seven public members, among whom most have a family member with an autism spectrum disorder (ASD). The Council also includes non-voting representatives from TEA, HHSC, DADS, DSHS, DARS, and DFPS, each of which provides financial support. DADS provides staff and administrative support for the Council. The Council chair appoints 10 regional advisory committee chairs representing all areas of Texas.

The Council's mission is to advise the Governor and make recommendations to state agencies and the state legislature to ensure that the needs of persons of all ages with ASDs and their families are addressed and that all available resources are coordinated to meet those needs. This is accomplished through the publication of a state plan for autism distributed prior to each legislative session, and an update to that plan published during the interim year,

From September 2006 through April 2008, the Council was a partner in the "Autism Spectrum Disorders Service Delivery Innovations" project funded by the Texas Council for Developmental Disabilities, managed by DADS, and implemented by Texas Tech University Burkhart Center for Autism Education and Research. The project conducted a statewide survey and produced a report that examined perceptions concerning the accessibility, effectiveness, and usage of ASD interventions and supports. The project also produced service provider data, which will be used to develop an on-line directory of autism services and supports in Texas.

Based on public input, and pertinent information such as the recommendations from the "Autism Spectrum Disorders Service Delivery Innovations" project, the state plan for autism will guide the Council as it continues to collaborate with member agencies to fulfill its mandate.

Ensuring Quality and Best Practices

State School Staffing Project and Best Practices Initiative

The Department received funding from the 80th Legislature to significantly increase the number of positions in the state schools. The Department is engaged in multiple

efforts to ensure that 1,690 newly allocated state school positions are filled according to an approved rollout schedule over the 2008-09 biennium. The additional positions have enhanced the ability of state school staff to further identify and implement best practices in a wide variety of service areas across the state school system. These efforts will lead to improved resident care. The best practices include the following:

- Standardized person-directed planning system,
- Standardized values-based culture training,
- Standardized unusual incident trend analysis system,
- Standardized assessment tools for the side effects of medications,
- Standardized rights assessments,
- Improved comprehensive quality enhancement reviews,
- Positive behavior support training and service provision,
- Statewide reduction in restraints and restrictive practices,
- Prevention and management of aggressive behavior, and
- Statewide competency based training by national expert consultants at all state schools.

Expansion of Online Quality Reporting System to Include Waiver Providers

The Department offers information on the long-term care Quality Reporting System (QRS) website to help individuals evaluate the quality of long-term care services. Individuals can use QRS to obtain specific information about a particular long-term care provider or to compare providers in a particular area. QRS provides information that can help individuals identify providers that may meet their family member's needs, but it is not meant to serve as the only basis for choosing a particular provider.

Information regarding institutional services has been available on the DADS QRS website for several years. The Department is currently expanding the QRS website to include the following waivers: CBA, CLASS, CWP, DBMD, MDCP, HCS, and TxHmL. The Home and Community-Based Program section of QRS reports on providers contracted with DADS to provide Medicaid waiver program services. The addition of the Home and Community-Based Programs provides individuals with more information to make informed choices about services available in their communities.

Facilitating Access to Services

Community Waiver Services Expansion/Rollout

The demand for many DADS community-based services and supports exceeds available resources. As a result, applicants' names are placed on an interest list until services are available. The Department was appropriated funds for the 2008-09 biennium to authorize enrollment for 4,993 individuals in Medicaid waiver

program services. The appropriation was to reduce the interest lists for the Medicaid waiver programs operated by DADS. This additional funding provides supports and services to older and disabled individuals in the community, allowing them to maintain their independence and prevent institutionalization.

Aging and Disability Resource Center Projects, Regional Access, and Intake Community Roundtables

The purpose of the federally funded Aging and Disability Resource Center (ADRC) projects is to provide communities with financial support for developing and implementing streamlined access to publicly funded long-term services and supports. Currently, Texas has three ADRCs providing services in Bexar County, Tarrant County, and five counties in Central Texas. The centers enhance the connections across DADS front doors (AAAs, MRAs, and DADS Regional and Local Services offices). In addition, DADS is holding community roundtable meetings in all regions with the Regional and Local Services staff, MRAs, and AAAs to review and improve access to services. Streamlining tests and pilots of the ADRC projects include:

- **Bexar County—**virtual co-location of its partner agencies, using streamlined telecommunications capability for the partners, as well as web-based applications, to exchange information and resources through their Network of Care system;
- **Central Texas—**co-location, in which staff from the major partners, including HHSC enrollment staff, is housed in one office space at the ADRC, with the exception of Scott and White Memorial Hospital; and
- **Tarrant County—**both a co-location and virtual model, in which community agencies are housed in a large, multi-office complex with automated telecommunications and a web-based data warehouse of consumer information that can be accessed to expedite applications for consumer services as well as to hold virtual meetings for interagency staffing questions and/or problem-solving.

The Department is issuing a request for proposal in June 2008 for $1.1 million to expand ADRCs in up to five additional sites.

Strengthening Provider Capacity

Implementation of Provider Rate Increases from 80th Legislature

Many provider rates have not kept pace with routine inflation or medical costs. Additionally, minimum wage increases and increasing gasoline prices have had a tremendous impact on provider costs. Rates were restored and increased for the non-state operated ICFs/MR, HCS, TxHmL, and CLASS programs in June 2007. In September 2007, rates were increased for non-state operated ICFs/MR, NFs, and other community providers (CBA, PHC, DAHS, TxHmL, CLASS, HCS, and other programs).

The Department worked with the HHS System's Rate Setting office to implement provider rate increases approved by the Legislature for the current biennium. The Department will continue to work with the Rate Setting office to request increases as needed to address inflation-related costs.

Texas Direct Service Workforce Initiative

In September 2006, HHSC and DADS received a grant from the National Direct Services Workforce Resource Center to provide technical assistance in identifying ways to improve recruitment, retention, and the paraprofessional status of the direct care staff in Texas. Activities related to this grant have included the following:

- In November 2006, 130 stakeholders from Texas and national experts participated in a forum in Austin coordinated by DADS;
- In July 2007, DADS held focus group discussions with stakeholders in El Paso, Houston, Progreso, and San Angelo regarding issues related to DSWs; and
- On January 17, 2008, stakeholders provided input regarding direct service workforce issues to the Promoting Independence Advisory Committee.

Coordinated Provider Meetings

Provider Services has quarterly meetings with home health providers, adult day care providers, and assisted living providers to share information of interest or importance to the provision of long-term services and supports. The Department's staff from Access and Intake, Contract Oversight and Support (COS), Regulatory Services, and Stakeholder Relations from the Center for Consumer and External Affairs also attends. The HHS System's Rate Setting Division and ICM areas attend as appropriate.

Promoting Long-Term Wellness

Aging Texas Well Initiative

The purpose of ATW is to identify and discuss policy issues on aging, guide state government readiness, and promote increased community preparedness for an aging Texas.

ATWI helps define strategies to prepare Texas in 16 life areas, with some focusing on individual preparedness and others focusing on societal infrastructure. From the individual perspective, ATW addresses the areas of physical health, mental health, social engagement, spirituality, and financial and legal preparedness. Societal infrastructural focus areas include employment, transportation, housing, volunteerism, community supports, and long-term services and supports.

Texercise Initiative

Texercise is a statewide fitness program developed by DADS to educate and involve older Texans and their families in physical activities and proper nutrition. The Texercise program promotes activity among individuals, community events, and policies that support fitness in all life areas. *Texercise: A How-To Handbook for Lifelong Health and Wellness* provides a fun, practical guide to exercise, including detailed explanations and illustrations of these four exercise types: endurance, balance, strength, and flexibility, along with nutrition tips, fitness facts, and a fitness log.

In addition, partnerships in Texas communities are a vital component for promoting Texercise. A long time supporter of DADS Texercise, RunTex continues to support initiatives that promote health and wellness. RunTex in-kind support includes donating new running shoes for individuals at senior centers and state schools that participate in the RunTex "Born to Run" fitness program.

Evidence-Based Disease Prevention Grant

In July 2006, the United States Department of Health and Human Services Secretary announced the release of more than $13 million, over three years, to Texas and 15 other states, to improve the health and quality of life for older Americans. Texas received $250,000 for FY 2007, $250,000 for FY 2008, and anticipates receiving $200,000 for FY 2009.

The Texas Healthy Lifestyles initiative consists of public and private evidence-based prevention programs empowering older Texans to take more control of their health and to reduce the risk of disease and disability. This initiative contributes to improved health for Texans through promotion of lifestyle changes that have proven effective in reducing the risk of disease and disability. The Department is collaborating with DSHS, the Bexar AAA, the Brazos Valley AAA, and Neighborhood Centers, Inc. in Houston, and their local community partners. The grant is being used to disseminate evidence-based physical activity programs with the goals of improved self-reported health status and symptom management, improved health behaviors, and reduced utilization of health care resources such as fewer hospitalizations, reduced use of the emergency room, and reduced visits to the physician.

Fall Prevention Project

The Department awarded a grant to the Texas Association of AAAs, which have entered into a collaborative partnership with Texas A&M Health Science Center School of Rural Public Health to improve fall prevention in Texas. The Texas Fall Prevention Coalition will implement the A Matter of Balance fall prevention strategy in 147 counties in Texas. The participating AAAs will disseminate the program by creating a statewide coalition of master trainers, master training sites, and a significant capacity to train local coaches and expand the program with local resources. The Fall Prevention Collaborative is to be piloted with the intent that

successful completion will result in positive outcomes and development of a replication strategy others can use to implement the innovation elsewhere in Texas. The pilot will address each of the following key components:

- Inherent risk factors for falls,
- External risk factors for falls,
- Thorough clinical and functional risk assessments of people who fall and their environments,
- A planning process which results in the development of person-centered interventions for fall prevention, and
- A systematic method of coordinating public and private resources to successfully address fall prevention activities within a community.

Interagency Collaborations

Supported Employment Leadership Network Initiative

Supported employment (SE) facilitates competitive work in integrated work settings for individuals with disabilities for whom competitive employment has not traditionally occurred. At DADS, SE is available in five home- and community-based waiver programs: HCS, TxHmL, CLASS, CWP, and DBMD. Historically, low SE utilization has existed among DADS consumers. Recently, much attention and work has been focused on addressing barriers to SE utilization.

In 2006, DADS joined the State Employment Leadership Network, a network of state developmental disability agencies, led by the Institute for Community Inclusion (ICI), that provides technical assistance to members regarding SE, such as identification of obstacles and best practices. As a result of this membership, DADS has not only gained resources (those of the ICI and of other states) focused on improving SE services in Texas, but also has improved coordination with DARS through revision and re-execution of an interagency memorandum of agreement. The network is also assisting DADS in creating a uniform SE definition (or set of definitions) and in developing a data system to capture meaningful employment outcomes.

Pursuant to H.B. 1230, 80th Legislature, Regular Session, 2007, the Department also participates in a workgroup charged with creating and implementing a plan to improve employment outcomes for transitioning youth with disabilities. With a greater percentage of consumers employed in competitive jobs, Texas businesses will achieve more diversity and a larger talent pool, while DADS will move closer to achieving its goal of maximum independence for individuals receiving long-term services and supports.

Mental Health Transformation Work Group

The Department participates as an active member of the Mental Health Transformation (MHT) Work Group. The Substance Abuse and Mental Health Services Administration awarded MHT State Incentive Grants designed to assist

states in transforming their mental health service systems to create a single, effective, transparent, and easily navigated system for consumers. Texas received this grant along with six other states, which are required to engage in focused leadership activities of planning and building infrastructure across all state agencies that provide funds, administer, and purchase mental health services.

Enterprise Executive Work Group – Long-Term Service Integration and Coordination

This workgroup ensures that long-term services and supports are coordinated across DADS and HHSC. Operational issues include, but are not limited to, managed care issues affecting individuals needing long-term services and supports. The workgroup will continue to invite stakeholders to present concerns to executives on cross-agency long-term services and supports operational issues.

Implementation of Integrated Care Management Pilot

The implementation of the ICM program resulted from H.B. 1771, 79th Legislature, Regular Session, 2005, and the 2006-07 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 49, S.B. 1, 79th Legislature, Regular Session, 2005). The Department has coordinated with HHSC and the ICM contractor, Evercare of Texas, L.L.C., to implement the ICM program, which provides a non-capitated primary care case management model of Medicaid managed care.

The purpose of the ICM program is to manage and coordinate acute care services and long-term services and supports for individuals in the Dallas and Tarrant service areas. The Dallas Service Area consists of the following counties: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall. The Tarrant Service Area consists of the following counties: Denton, Hood, Johnson, Parker, Tarrant, and Wise. ICM long-term services and supports include PHC and DAHS. ICM members may also be eligible for the ICM 1915(c) waiver, which offers the same array of services as the CBA waiver.

The HHSC ICM program began enrolling members in December 2007. ICM participants began receiving services through the program on February 1, 2008.

Long-Term Care Insurance Partnership Program

The overall growth of the aging population has led states to examine ways to reduce the impact of growing long-term care costs on state Medicaid resources. In an effort to minimize this impact in Texas, HHSC, DADS, and the Texas Department of Insurance (TDI) are undertaking an initiative to develop and implement the Long-Term Care Partnership plan, authorized under the federal DRA. The Partnership program is a public-private partnership between state agencies and private insurance providers to offer long-term care insurance. The program provides an option for individuals to plan for their future long-term care needs and protect resources. It is also intended to reduce Medicaid expenditures by delaying or eliminating the need for individuals to rely on Medicaid for long-term care services.

This partnership program was authorized in Texas by S.B. 22, 80th Legislature, Regular Session, 2007. Provisions of the bill include the following:

- $600,000 in GR funds in FY 2009 for staffing, operations, and an outreach campaign;
- Authorization of additional full-time employees for the Partnership; and
- Requiring HHSC, DADS, and TDI to develop and implement the program, including:
    - Adoption of rules as necessary;
    - Development of standards for certifying agent training and understanding of partnership policies (HHSC and TDI); and
    - Development and implementation of a long-term care awareness campaign to educate Texans on the cost of long-term care and the limits of Medicaid eligibility and Medicare benefits, and to encourage individuals to purchase long-term care insurance.

DADS Goal 2: Regulation, Certification, and Outreach

Provide licensing, certification and contract enrollment services, as well as financial monitoring and complaint investigation, to ensure that residential facilities, home and community support services agencies, and individuals providing services in facilities or home settings comply with state and federal standards and that individuals receive high-quality services and are protected from abuse, neglect, and exploitation.

Target Populations and Service Descriptions

This section gives an overview of the programs and services provided by the Regulatory Services Division of DADS. These services include licensure, credentialing, certification, survey, and enforcement activities.

Regulatory Services

The Department provides licensing, certification, financial monitoring, complaint investigation, and enforcement. These regulatory functions ensure that NFs, adult day care providers, ALFs, ICFs/MR, home and community support services agencies, and individuals providing services in facilities or home settings comply with state and federal standards. These functions also ensure that individuals receive high-quality services and are protected from abuse, neglect, and exploitation. The Regulatory Services 2007 Annual Report provides data about these DADS services.

Through licensure and certification inspections and complaint and incident investigations, DADS staff determines that regulated facilities and agencies comply with the federal and state rules appropriate to the services they provide. Survey

staff determines if providers are meeting the minimum standards and requirements for service, identify conditions that may jeopardize client health and safety, and identify deficient practice areas. When deficiencies are identified and cited, survey staff monitors the provider's plan of correction to ensure areas of inadequate care are corrected and compliance with state and federal requirements is maintained. State licensure and federal certification requirements include numerous enforcement actions that DADS may pursue to encourage providers to correct problems of noncompliance.

By statute, facilities meeting the definitions of NFs, ALFs, adult day care facilities, and privately owned ICFs/MR must be licensed and must comply with all licensure rules to operate in Texas. Publicly operated ICFs/MR, those operated by the State of Texas and locally governed community MHMR Centers, and skilled nursing units in acute care hospitals must be certified to participate in the Medicaid program. Home and Community Support Services Agencies (HCSSAs), which include home health, personal assistance services, and hospice, also fall under the Department's licensing and certification review functions. In FY 2007 DADS regulated 1,179 NFs; 1,452 ALFs; 4,484 HCSSAs; 877 ICFs/MR; and 430 adult day care facilities. Additionally, DADS conducts annual, on-site reviews of 476 HCS waiver contracts and 148 TxHmL waiver contracts for compliance with the program certification principles. Based on the review, corrective actions may be required and sanctions imposed. The Department is responsible for investigating complaints related to HCS and TxHmL services. The Department also receives and follows up on DFPS findings related to abuse, neglect, or exploitation investigations of individuals who receive HCS or TxHmL services.

The Department has oversight, administrative, and regulatory responsibilities related to long-term services and supports to a target population of 535,783 individuals who are older or have disabilities. In FY 2007, there were 91,496 individuals living in NFs; 31,033 individuals living in ALFs; 19,172 individuals receiving services in adult day care facilities; and 367,715 individuals receiving services in their own home or community through regulated HCSSAs. Additionally, there were 4,873 individuals receiving services in state mental retardation facilities; more than 6,600 people in community ICFs/MR; and more than 14,875 individuals participating in TxHmL and HCS waiver programs.

Licensing and Credentialing Services

When a provider applies for licensure, the division reviews the applicant’s history as a provider, obtaining detailed information on operators, owners, and other controlling persons. The division assesses all the information and approves or denies the application.

The Department’s Licensing and Credentialing sections administer four credentialing programs. Through these programs, DADS licenses, certifies, permits, and monitors individuals to determine whether they can be employed in facilities and agencies regulated by the Department. The programs provide a means of ensuring these

health professionals meet specific standards in providing care to individuals receiving long-term services and supports.

The Nurse Aide Training and Competency Evaluation Program is responsible for reviewing and approving or withdrawing approval of nurse aide training courses and skills examinations and for certifying nurse aides to provide services in DADS licensed facilities. The Nurse Aide Registry Program is responsible for maintaining a registry of certified nurse aides and providing due process considerations and determinations of employability in nursing and other facilities. In FY 2007, there were 119,049 active certified nurse aides.

In relation to the administration of NFs, the Nursing Facility Administrator Licensing Program is responsible for licensing and continuing education activities, imposing and monitoring sanctions, providing due process considerations, and developing educational curricula. In FY 2007, there were 2,079 active NF administrators.

The Medication Aide Program is responsible for medication aide permitting and continuing education activities, permit issuance, and permit renewal. Along with permitting aides, the program is responsible for imposing and monitoring sanctions and providing due process considerations. Other activities include approving and monitoring medication aide training programs in educational institutions, developing educational curricula, and coordinating and administering examinations. In FY 2007, there were 9,653 active permitted medication aides.

Quality Assurance and Improvement (Long-Term Care Quality Outreach)

The Quality Monitoring Program

The Quality Monitoring Program is staffed with nurses, dieticians, and pharmacists who are deployed to provide clinical technical assistance to NFs statewide. Staff schedules visits with NFs to review quality in facility-chosen focus areas. The 15 evidence-based best practice focus areas are directly related to quality of care and quality of life and currently include topics such as fall risk assessment, pain assessment and management, vaccinations, the use of restraints, unintended weight loss, and medication simplification. Quality monitoring staff also provides in-service training to NF staff and residents' families upon request. The program is currently under expansion to include ICFs/MR.

Quality Reporting System

QRS is a web-based resource that provides consumers with information about providers of long-term services and supports. It also synthesizes information that helps people compare providers of similar services. The system is available at http://facilityquality.dads.state.tx.us. Current provider groups covered on QRS include:

- NFs,
- ICFs/MR,

- State mental retardation facilities,
- ALFs,
- Adult day care providers,
- Home health agencies, and
- Providers of home- and community-based services through the Medicaid waiver programs.

Quality Reviews

The Department conducts two annual reviews of quality that randomly select and interview more than 4,000 individuals receiving services. The Nursing Facility Quality Review provides an assessment of the individuals' satisfaction with their quality of care and quality of life in NFs, and performs onsite case reviews of the care of NF residents.

The Long-Term Services and Supports Quality Review is an annual statewide survey measuring quality of care and quality of life of people receiving services and supports through home- and community-based and ICF/MR programs. The results of both reviews are published on the DADS website.

Aging and Disability Symposia

The Department has sponsored symposia for several years on clinically related quality topics, such as care planning, infection control, and pain management, that are relevant to the needs of people who are aging or have disabilities. Future symposia will be developed in collaboration with stakeholders. The next two symposia are planned to cover the two topics of caring for persons with dementia, and supporting individuals who have challenging behaviors. Presenters will include medical experts, nurse-researchers, and provider industry personnel.

DADS Goal 2 Trends and Challenges

Reducing Risk at Long-Term Services and Supports Facilities

Meeting Demand for Qualified Regulatory Surveyors and Other Staff

While Regulatory Services has made many strides in the area of staff recruitment and retention, several factors present challenges. For example, the salaries for regulatory personnel in professional disciplines including surveyor ranks (nurses, architects, dieticians, and social workers) are not comparable to industry salaries; there is a shortage of nurses; and travel schedules are heavy. Additionally, properly training a surveyor is time- and resource-intensive. All surveyors must complete required federal training before they can participate on a survey team. This training is scheduled by CMS, and it can take up to six months for a surveyor to be fully prepared to assume all job responsibilities. Therefore, turnover in these types of positions imposes particularly high costs on DADS.

Maintaining a fully staffed and well-trained workforce is critical to the effective operation of the Regulatory Services Division. The ability to recruit and retain a qualified workforce is imperative to fulfilling survey and complaint investigation requirements and keeping up with ever-changing policies and growth in the number of long-term care providers and recipients of services.

Quality of Services

A higher quality of care is an expectation of the public, the Legislature, and DADS. The Department promotes continuous improvement and increased quality of care through evidence-based best practices and innovations.

Beyond the existing long-term services and supports QR process, DADS needs to further examine available data from long-term services and supports providers to identify new quality of care indicators. For example, data elements in the Minimum Data Set provide simple yet very reliable observations (e.g., reporting restraint and catheter use), while other data that require interpretation or complex observation are less reliable (e.g., reporting of specific medication types and staging pressure sores).

The Department needs to continue to measure the quality of certain services, to identify specific opportunities for improvement, and to measure whether the Department's technical assistance interventions are yielding actual improvements in those services. The improvement of services not only needs to be monitored for NFs, but for all facility and community service settings.

Need to Identify Nursing Facilities at Risk of Financial Difficulties

The long-term care industry experienced a rise in NF insolvency and bankruptcy filings in the late 1990s. For example, in 1999 the NF trustee program was utilized to assume operations of 13 facilities where financial considerations impacted the health and safety of residents. This trend continued in 2001. When a provider abandoned 15 of its facilities, the trustee program was utilized again to assist with relocation of residents. In July 2005, a bankruptcy court requested the placement of three trustees over 13 facilities because of the provider's inability to make payroll.

Financial problems in the NF industry continue today. During FY 2007, the NF trustee program was utilized to assume operations of three NFs experiencing financial difficulties. Since January 2007, 23 NFs have closed. These closures were fueled by financial constraints, low census, and noncompliance with Medicare certification requirements. In February 2007, representatives of the Internal Revenue Service (IRS) indicated that they are aware of Texas NFs that owe substantial amounts of money to the IRS due to nonpayment of payroll taxes. Since then, the IRS has increased its activity related to tax liens and levies.

Consideration of the current financial problems in the NF industry should include the potentially far-reaching ramifications of a provider's financial stability. These

ramifications can be quite broad and may affect residents' well-being. For example, residents may face food shortages, families may be forced to relocate a loved one to another facility, and communities may face loss of jobs. The Department may be compelled to relocate residents and pay costs associated with the placement of a trustee from the Nursing and Convalescent Home Trust Fund. The trust fund's balance, which is a maximum of $10 million, could be significantly reduced by the closure of one or a combination of several NF providers and additional assessments could be needed to replenish the fund.

DADS Goal 2 Initiatives

The following initiatives represent DADS efforts to respond to the trends and challenges of Goal 2, Regulation, Certification, and Outreach, identified in the previous sections. They correspond somewhat to the identified trends or challenges.

Ensuring Quality and Best Practices

Addressing Demand for Regulatory Services Staff

In 2005, to address the demand for regulatory surveyors and other staff, Regulatory Services was given permission to raise the base salaries of some surveyor job classifications. Additionally, Regulatory Services provided tools to assist surveyors and other staff in more effectively and efficiently carrying out their job responsibilities; the division increased flexibility in work schedules and office locations; and the division improved methods of communication throughout the organization. As the result of this focus and these consistently applied recruitment and retention efforts, the turnover rate decreased from 22.4 percent in FY 2005, to 19.7 percent in FY 2007.

Expansion of Quality Monitoring

The Department is developing and implementing a quality monitoring program to improve outcomes and services for individuals served in state schools, ALFs, and privately owned ICFs/MR. Currently DADS Quality Assurance and Improvement Unit is coordinating with the State Mental Retardation Facilities Quality Enhancement Team and the Program Improvement Unit to implement a Quality Consulting Program in state mental retardation facilities. The purpose of the program is to increase positive outcomes for individuals served in state mental retardation facilities. Preliminary focus areas include: nursing practice, dehydration, unintended weight loss, and polypharmacy. In the future, the program will be expanded to ALFs and other ICFs/MR. This program is supported by Chapter 255 of the Health and Safety Code.

Nursing Facility Financial Viability Project

The purpose of the Nursing Facility Financial Viability Project is to develop a system for DADS to obtain and analyze financial information from applicants for initial (including changes of ownership) or renewal applications for NF licensure on an

initial and ongoing basis. The project, which was initiated by the Department of Human Services, involved consulting with stakeholders, reviewing documents on NF viability, compiling other states' practices in NF viability, and developing a briefing paper. Since then, DADS has worked extensively with staff of the HHS System's Office of Inspector General who has expertise in conducting desk reviews and field audits of the Texas Nursing Facility Cost Reports to develop a revised application for NF licensure that requires applicants to provide general financial information.

DADS Internal Assessment

DADS Internal Operations

The functional organizational structure of DADS facilitates achieving the agency's goals. Each division has unique responsibilities and a shared focus of supporting the comprehensive array of long-term services and supports for older Texans and persons with disabilities. The agency is divided into the following programmatic and support divisions that each report to the Commissioner:

- Deputy Commissioner,
- Internal Audit,
- Chief Financial Officer,
- Chief Operating Officer,
- Access and Intake,
- Provider Services, and
- Regulatory Services.

The Deputy Commissioner oversees the Center for Policy and Innovation, the Center for Program Coordination, and the Center for Consumer and External Affairs. These centers are responsible for providing policy direction and technical assistance to improve services, coordinate business processes, and ensure accurate and timely external communications.

The Internal Audit section is charged with providing independent, objective assurance and consulting activities designed to improve DADS operations. This section helps DADS accomplish identified objectives by bringing a systematic, disciplined approach to evaluating and improving the effectiveness of risk management, control, and governance processes. Internal Audit reports directly to the Commissioner to ensure independence.

The Chief Operating Officer (COO) oversees Legal Services, Consumer Rights and Services, Information Technology, Contract Oversight and Support, and Executive and Staff Operations. The Division is also responsible for some program and

service-related administrative support activities and for coordination with HHSC to ensure the effective and efficient delivery of administrative support services to the HHS System agencies.

The Chief Financial Officer is responsible for Accounting, Budget and Data Management, and Claims Management. The responsibility of financial management and oversight includes:

- Preparing the biennial Legislative Appropriations Request;
- Preparing the Annual Financial Report;
- Developing fiscal notes analyzing the financial impact of proposed legislation;
- Managing the daily accounting, budget, and claims management processing functions;
- Preparing and managing the annual operating budget; and
- Conducting work measurement studies to determine the resources needed to deliver services.

The Assistant Commissioner for Access and Intake is responsible for AAA, MRA, Regional and Local Services, and Guardianship Services. The primary function of the division is to ensure that DADS services at the local level are accessible through a coordinated and efficient system. Additionally, the division provides functional eligibility determination, development of individual services based on consumer needs and preferences, assistance in obtaining information, and authorizing appropriate services and supports.

The Assistant Commissioner for Provider Services is responsible for Institutional Services, Community Services, and State Schools. Provider Services contracts with and oversees contracts with hundreds of community and in-home service providers. The division ensures that consumers have a full array of services delivered by qualified providers. The division also ensures better coordination across models of care, integrating practices that achieve higher quality of care for individuals receiving services. Through its State Schools Section, Provider Services manages 11 state schools and two centers providing services to individuals with mental retardation or related conditions.

The Assistant Commissioner for Regulatory Services is responsible for Licensing and Credentialing Operations, Survey Operations, and Enforcement Operations. This responsibility includes technical and professional review in the process of licensing and credentialing of long-term services and supports providers; administration of local survey operations, policy, compliance, and oversight; and enforcement of licensing and credentialing standards.

DADS Internal Trends and Challenges

Agency Staffing

Recruitment and Retention

Vital to the effective and efficient delivery of services is DADS' ability to recruit and retain a well-trained and capable workforce. As the need for DADS services continues to grow, so do the challenges DADS faces with recruiting. The Department has been challenged with high vacancy and turnover rates in positions including surveyors, mental retardation assistants, and other health care professionals.

The Department's recruitment challenge in recruiting is the result of an increased shortage of qualified applicants, particularly in rural areas and nurses. As an aging workforce nears retirement, and given the concurrent decline of enrollment in nursing schools, the demand for nurses is projected to continue to outpace supply. In addition, an increasing number of nurses are changing careers in favor of less stressful and more flexible work environments. Although FY 2008 equity adjustments for nurses have contributed to retention and increased salaries have attracted more applicants, it will still be difficult to fill all vacancies.

The retention of employees also poses a challenge to Texas state agencies including DADS. The statewide turnover rate for all state agencies for full-time and part-time classified employees in FY 2007 was 17 percent. However, the turnover rate for DADS during the same period was 30 percent. Although no DADS physicians left state employment in FY 2007, DADS still experienced a physician turnover rate of 18 percent due to physicians taking jobs at other state agencies. The Department has 22 physicians and psychiatrists who will be in a retirement-eligible status within the next year: those who are return-to-work retirees, those who are eligible to retire now, and those who will be eligible for retirement. This represents 52 percent of the agency's current physician and psychiatric staff.

In addition, many pharmacists are nearing retirement. Of DADS pharmacists, 43 percent will be in a retirement-eligible status within the next six years. Retirement of our physicians, psychiatrists, and pharmacists will create a tremendous void and significantly increase the challenge of providing quality health care for unique and fragile populations. The FY 2007 statewide turnover rate for mental retardation assistants and supervisors was 40 percent, while DADS' turnover rate was 49 percent. This 49 percent turnover rate is significant since 54 percent (6,080) of the filled FTEs at DADS state schools consisted of mental retardation assistants and supervisors during FY 2007. Turnover for these positions at some of the state school facilities was as high as 73 percent during FY 2007.

The FY 2007 statewide turnover rates for registered nurses and licensed vocational nurses were 20 percent and 27 percent, respectively. During this same period, the DADS turnover rates were 25 percent and 31 percent, while the rates at state school facilities were 30 percent and 31 percent.

Staff Training and Continuing Education

Educational Services within Executive and Staff Operations of the COO serves as a training resource for DADS. The mission of Educational Services is to provide effective and timely training that supports agency staff in the provision of quality services and to promote quality of life for individuals receiving long-term services and supports. Educational Services provides training and education to both internal and external customers.

Courses are open to all levels of staff at various capacities and with specific roles and responsibilities. Through continuing leadership and program specific training, employees continually increase their knowledge and become more skilled and effective in implementing and enforcing DADS programs and promoting sound business management practices. To ensure DADS meets its goals and mission, Educational Services also provides training to the provider industry responsible for the care of individuals in facilities or in their homes.

The principal challenge with regard to education and training has been to accommodate the increase in the number of field staff hired. Specifically, keeping staff trained in a timely manner continues to challenge current training resources.

Supporting Business Processes

DADS Service Approval Systems

As the result of consolidation of HHS System agencies in September 2004, DADS inherited two long-term services and supports service approval systems. These systems are the Service Authorization System (SAS) and the MR Client Assignment and Registration (CARE) mainframe system. The purpose of these systems is to enroll consumers in long-term services and supports programs and to verify their services. However, the use of two separate and incompatible service approval systems poses several risks. Examples of these risks are:

- Possible duplication of enrollment in DADS 1915(c) waiver programs; and
- Possible inconsistencies and errors with data inquiries, analysis, program comparison, and reporting.

Enhancements to SAS are necessary to eliminate manual paper and data entry processes, such as those regarding levels of care and individual service plans.

Integrated Billing and Payment System

The Department processes billing and payment requests through two separate systems. The processing of HCS and TxHmL providers billing and payments occurs through the MR CARE mainframe system. The billing and payments for other DADS programs are processed through the Claims Management System operated by the Texas Medicaid & Healthcare Partnership (TMHP). The Center for Medicare and Medicaid Services approved the Claims Management System as a Medicaid Management Information System making it eligible for enhanced federal match for

system modifications and improvements. The Client Assignment and Registration mainframe system does not have this designation.

Two concerns arise because all billing and payments processing for all of DADS long-term services and supports programs are not consolidated into the Claims Management System. These concerns include:

- Inefficiency related to billing and payments being processed weekly for the HCS and TxHmL programs and daily for all other DADS long-term care programs, and
- Unavailability of enhanced federal match for system modifications and improvements to the CARE mainframe system for the HCS and TxHmL programs.

Improving Contract Monitoring

Multiple contracting processes used for contract oversight and monitoring at DADS have resulted in duplicative work for the COS staff and increased processing risks, such as inconsistency of data. The Department became aware of these risks as a result of recommendations from two previous audits of the monitoring process by the State Auditor's Office (SAO). A risk assessment would facilitate identifying where contract oversight and monitoring improvements are needed.

Information Technology Needs

Security Data Encryption

Information is a core asset at DADS. Reliable, timely access to accurate information is a fundamental DADS business function. In particular, DADS has been entrusted with private health information about individuals participating in long-term services and support from DADS programs. The Department has an obligation to protect client privacy by ensuring the confidentiality of such information maintained in its information technology (IT) systems. In addition, DADS must comply with Texas Administrative Code Section 202 as well as Health Insurance Portability and Accountability Act and other federal requirements. With an ever-increasing emphasis on security, securing confidential information both inside and outside the Department is essential. While there are controls now in place that require password entry at the operating system level, these controls do not offer full robust protection of data that reside on agency equipment.

Dependence on Contracting IT Staff

With the consolidation of the HHS System agencies in September 2004, the demand for IT projects to comply with legislative mandates and to meet the needs of DADS consumers has increased. This level of demand exceeds the capacity of DADS IT resources in terms of number of staff and technological skills availability.

To meet demand, DADS IT staff is augmented through the use of contractors, a practice that has become increasingly common. A recent comparison performed by the DADS IT division shows a significant increase in funds expended on contracted resources during the last biennium. Compared to costs incurred in FY 2006, funding for contract staff increased by more than 61 percent in FY 2007. Further analysis shows that if the DADS IT workforce remains at current levels, the trend toward increased use of contractors will continue.

These contractor cost increases are difficult to sustain, and an investment in additional employees at appropriate skill levels with on-going training and development will benefit DADS. Continued limitation of resources poses a risk to DADS' capacity to meet future demands for sustaining current technology and optimizing consumer services through emerging technology.

Aging Telecommunications Equipment and IT Hardware at State Schools

Critical to ensuring communication among residents, their families, and staff is reliable telephone systems and IT hardware at the state schools. The telephone systems at the state schools are aging. As a result, voicemail systems, network switching of incoming and outgoing telecom trunks, and the uninterruptible power sources (UPS) are all unreliable.

The voice mail systems at the state schools are no longer supported with maintenance contracts. If system failure occurs, repairs on current systems at state schools may not be available due to shortage of refurbished parts.

The IT network switches at state schools are more than 10 years old and are no longer covered and supported with a maintenance contract. The IT hardware includes server and web-based applications necessary for staff to perform their jobs. In the event of a switch failure, the downtime could be extensive.

In the event of a power outage, the UPS should provide backup power for all network switches and servers at the state schools, allowing accessibility to data on residents of state schools. However, the backup power source is outdated and has a high failure rate.

Communication, Awareness, and Education

Enhancing Communication

Demographic changes, including increased numbers of older Texans and increased numbers of individuals with disabilities, will require more robust communication efforts to raise awareness about DADS services. Additionally, demographic trends in the state's population point to increases in demand for information to be provided to individuals in languages other than English or Spanish. Finally, in an effort to respond to increased demands for DADS services, it will become increasingly critical to effectively promote DADS employment opportunities. A more effective public

awareness strategy that responds to the needs of an increasingly diverse population will include use of both electronic communication tools, such as the Internet, and traditional tools, such as printed materials.

Strengthening Community Partnerships

Working in partnerships strengthens DADS' connection to local communities. However, creating partnerships continues to be challenging for a variety of reasons. For example, many individuals, companies, and businesses are unaware of the individuals whom DADS serves, or they are reluctant to partner with a state agency. In addition, volunteers have multiple requests for their time and financial resources. To address these challenges, DADS continues to look for new opportunities to inform potential volunteers and businesses about how to become involved and partner in DADS programs.

DADS Internal Initiatives

Agency Staffing

Maintaining Essential Regulatory and State School Staff

To successfully address the challenges presented by high vacancy and turnover rates, DADS is looking for ways to respond to the labor market and the needs of its current and potential employees. The Department continues to seek innovative ways to recruit and retain employees, with the goal of increasing applicant pools and reducing vacancy rates.

The Department has implemented several management recruitment strategies to increase awareness of job opportunities, specifically in Regulatory Services and at state schools. Examples of these strategies include:

- Publication of a website with information about available DADS career opportunities,
- Increased use of local and national media to advertise jobs,
- Participation in career fairs at colleges and universities,
- Collaborative partnerships with professional health care organizations to increase awareness about career opportunities, and
- Placement of a recruitment coordinator and a recruitment plan at each state school.

Staff Training and Education

To facilitate addressing challenges due to increased demands from staff and providers for training and education, DADS Educational Services has developed and implemented several new training programs. "Just in Time" training allows both providers and staff to receive training just before they are expected to implement the information and has proven to be most effective. However, tallying the numbers of

persons to be trained on any given subject creates challenges in deciding how and where the training will take place.

Web-based training is becoming a popular means to educate both internal and external customers. However, web-based training is best utilized when there is a limited amount of information that needs to be conveyed and works best with information that is concrete, such as a new rule or policy.

Supporting Business Processes

Creation of a Single DADS Service Approval System for All DADS Long-Term Services and Supports Programs

The Department is including an exceptional item in its Legislative Appropriations Request for the 2010-2011 biennium to create a single DADS Service Approval System (SAS) for long-term services and supports. The benefits of creating a single DADS SAS and making system improvements to the DADS Service Authorization System include:

- Consolidation of all consumer information/assessments into a common database eliminates the possibility of duplicate enrollment in more than one DADS 1915(c) waiver program, and
- Enhanced capability for data inquiries, analysis, program comparison, and reporting.

Along with the creation of a single DADS SAS, enhancements will be made to automate submission of service authorization documents, such as levels of care and individual service plans.

Integration of Billing and Payment Systems

The Department has a project under way to integrate billing and payments processing for HCS and TxHmL into the Claims Management System operated by TMHP. This project is scheduled for implementation in November 2008. This project will increase efficiencies by allowing:

- Use of the same processing rules for all DADS long-term care programs, and
- Enhanced federal match for all system modifications and improvements when changes need to be made.

Standardization of Contract Monitoring Process

A major initiative at DADS has been developing a standardized and comprehensive risk-based contract monitoring protocol. The Department's COS section is coordinating with other DADS programs to accomplish this initiative. The protocol will promote efficiency and consistency in monitoring contractors and will address the SAO recommendations. This initiative is expected to enhance the statistical

validity and reliability of contract monitoring results and improve accuracy in assessment of contractor performance and risk.

The contract monitoring tools have the following components:

- Risk assessment of the contractor,
- Sampling methodology (revised from current practice), and
- Program and fiscal compliance portion specific to each program.

The division conducted risk assessment workshops that informed tool development and then piloted selected program tools. Four tools are nearing completion. These four have been shared with internal stakeholders and, pending approval from the Commissioner, will be shared with external stakeholders. Implementation is planned for FY 2008, depending on workload of the program areas. The Department's COS section will continue development of additional program tools following the roll out of the initial four. Development will continue through FY 2009.

Meeting Information Technology Needs

Improving Security Data Encryption

The Department's collaboration with the HHS Enterprise efforts to address security gaps and associated funding constraints are ongoing. Collaborative efforts to address security gaps include providing end-user training, promoting security awareness, using published HHS Security Guidelines, and following IT standard operating procedures. For the 2010-11 biennium, DADS plans to request additional appropriated funding to expand its security program and provide full data encryption of desktops and laptops.

Reduced Dependency on Contracting IT Staff

The Department is looking for ways to reduce dependency on contracting for staff. Hiring FTEs would provide a significant cost savings to DADS by providing the same support at a significantly lower cost. For the 2010-11 biennium, DADS plans to request an increase to the FTE ceiling in order to reduce the dependency on the need to use contract staff.

Replacing Aging Hardware and Telecom Equipment at State Schools

Updating the IT hardware and telecom equipment at state schools will provide more reliable systems of communication for residents, their families, and staff. Improved reliability will enable faster problem resolution and less downtime at state schools. For the 2010-11 biennium, DADS plans to request appropriate funds to replace copper trunks with Integrated Services Digital Network Primary Rate Interface lines, voicemail systems, the UPS, and other equipment.

Communication, Awareness, and Education

Facilitating Consumer Access to DADS

The development of emerging communication technologies within the last decade provides DADS with new tools to enable Texans to more easily find information about the agency's long-term supports and services. During the past year, DADS developed a provider portal website to streamline the delivery of program-related communications to all interested parties. The agency is currently developing a companion consumer portal website that can serve as a simple research tool for individuals interested in agency-funded programs. The consumer portal will include hyperlinks to online resources such as QRS, 2-1-1 Information and Referral, Food Stamps, long-term care insurance, Medicaid eligibility, STAR+PLUS managed care, and other relevant services.

In addition, DADS is exploring opportunities to use other communications tools to share vital information with the general public. As a growing percentage of Texans obtain Internet access at either their home or work, the World Wide Web has become a viable communication medium for individuals in various socio-economic backgrounds. Expanded Internet access provides the agency with an additional resource for providing information quickly to targeted populations. The agency has also taken steps to obtain public feedback on its services via live web-casting and through online feedback tools via the agency's main Internet site.

Expanding Community Partnerships

The Department is expanding community partnership opportunities through its promotion of the Silver Lining and the Texas Your Neighbor initiatives, which will raise the public's awareness about DADS services and supports. Through planned social visits and activities, the Silver Lining program provides companionship opportunities for individuals residing in NFs and assisted living centers. Texas Your Neighbors is a statewide partnership among DADS, the state schools and centers, and businesses. These partnerships address the needs of all involved by offering a variety of opportunities to build supportive relationships, create skills training, and provide employment for individuals residing at the state schools and centers.

Chapter VII

Department of Assistive and Rehabilitative Services External/Internal Assessment

The material in this chapter is arranged as follows:

- Challenges and Opportunities;
- Current Activities by Goal:
  - Target Populations;
  - Service Descriptions; and
  - Trends and Initiatives;
- Internal Assessment.

Challenges and Opportunities

Services to Veterans

The United States (U.S.) Department of Veteran's Affairs (DVA) estimates the total number of veterans in the country to be 23,532,000.[1] Military veterans returning to Texas from duty overseas represent a population that may benefit from increased access to program sat the Department of Assistive and Rehabilitative Services (DARS). Currently, DARS has a memorandum of agreement (MOA) with the DVA-Vocational Rehabilitation and Employment Services (DVA-VRE) program. The objective of the MOA is to coordinate vocational rehabilitation and independent living services with those provided by DVA-VRE to maximize services and improve outcomes. The DVA-VRE program is authorized by Congress under Title 38, Code of Federal Regulations, Chapter 31. The mission of the VRE is to help veterans with service-connected disabilities to prepare for, find, and keep suitable jobs. For

[1] DVA, Office of Policy and Planning National Center for Veterans Analysis and Statistics, January 24, 2008.

veterans with service-connected disabilities so severe they cannot immediately consider work, VRE offers services to improve their ability to live as independently as possible.

DARS is placing a renewed emphasis on the collaboration in accordance with the MOA. The beginning of this effort is a query of current service delivery by DARS to indicate the number and location of consumers identified as veterans. This will ensure proper targeting of areas with high numbers of veterans. To further ensure a veteran is not delayed in receiving needed services, DARS will provide additional training for vocational rehabilitation (VR) counselors regarding the purpose of the MOA and the procedures outlined in it. DARS needs to establish local contracts with each DVA office to ensure clear communication and outreach.

Veterans with traumatic brain injury (TBI) and traumatic spinal cord injury (SCI) seek Comprehensive Rehabilitation Services (CRS) program services in very small numbers. Over the last eight years, five to seven percent of consumers in the CRS program have been veterans. This percentage has not been increasing. However, given recent estimates about the rising number of veterans diagnosed with TBI and SCI, the number and percentage may increase.

Foster Home Placements for Deaf and Hard of Hearing

Senate Bill 758, 80th Legislature, Regular Session, 2007, requires the Department of Family and Protective Services (DFPS) to work with the DARS Office of Deaf and Hard of Hearing Services (DHHS) to find suitable foster parents for children with a hearing loss. A lack of communication between the foster parent and child often leads to behavioral problems. Appropriate placement of children with hearing loss is vital to the overall well-being of the child and, ultimately, dictates the success of the relationship between the foster parent and the child.

A workgroup involving DARS and DFPS has been established to improve services to individuals who are deaf or hard of hearing. In discussing the various issues relating to foster care placement of children who are deaf or hard of hearing, the workgroup realized that unique challenges are also present regarding placement of children who are blind. Representatives from the DARS Blind Services programs were invited to participate in the workgroup, and the workgroup has expanded its focus to include persons who are deafblind or blind.

To recruit foster parents with sign language skills, DARS and DFPS developed a brochure that will be added to the websites for DFPS, DARS, and the Texas School for the Deaf and it will be generally distributed to potential foster care parents. This workgroup has initiated an ongoing relationship involving DARS and DFPS to continually identify avenues to recruit foster parents who can address the needs of children who are deaf, hard of hearing, deafblind, or blind. Standards of care have been established for individual and group foster homes and for residential facilities.

These standards, once approved, will apply when a foster home or facility accepts a child who is deaf, hard of hearing, or deafblind. The workgroup will also address the ongoing problem of finding qualified foster placements. By ensuring proper placement of children who are deaf, hard of hearing, or deafblind, DARS and DFPS increase the likelihood of the overall success and well-being of the child.

Diabetes Demographic

DARS has an opportunity to continue providing education and training for consumers with diabetes. With training, consumers experience fewer complications resulting from diabetes and are in a better position to become employed, remain employed, and live more independently.

The prevalence of diabetes continues to increase. In 2006, approximately 1.3 million people in Texas were diagnosed with diabetes. People with diabetes have a greater risk of experiencing vision loss from diabetic retinopathy, cataracts, and glaucoma. Each year, as many as 25,000 people become blind as the result of diabetic retinopathy. Diabetes is the leading cause of blindness for adults from 20 to 74 years of age.

Diabetes affects ethnic groups differently, with African Americans and Hispanics having higher prevalence rates than Anglos. In addition, the Hispanic population is growing faster than other ethnic groups, and this faster growth will likely impact the number of Texans who are diagnosed with diabetes and who may lose significant vision as a result of the disease. According to the American Diabetes Association, in 2006 the total cost of diabetes for Texas was estimated at $12.5 billion. This includes medical costs of $8.1 billion attributed to diabetes, and lost productivity valued at $4.3 billion.

Fortunately, significant improvement has been shown to be possible through rehabilitation programs educating people about diabetes self-management skills, nutrition counseling, and exercise programs.-

Qualified Interpreters in the Public School System

Recent amendments made to the Individuals with Disabilities Education Act (IDEA) established qualifications for services personnel and paraprofessionals who are providing special education or related services. The amendments require that these employees must have qualifications consistent with any state-recognized certification, licensing or registration, or other comparable requirements that apply to their professional discipline. Based on these additional requirements, the Texas Education Agency (TEA) established that schools providing interpreting services to students who are deaf or hard of hearing must ensure that interpreters hold appropriate certification either from the professional organization known as the

Registry of Interpreters for the Deaf or from DARS, Board for Evaluation of Interpreters. This requirement became effective October 13, 2006.

Retaining and recruiting qualified interpreters in the public school system remains an issue. A major obstacle for recruitment of interpreters is low pay. Although some school districts pay well, others do not, and there is no standard pay scale for interpreters. With the new certification requirement, some school districts increased the pay level, but this effort did little to alleviate the shortage, since many individuals working as interpreters could not obtain the required certification. There is also a lack of interest in entering the field of interpreting, due largely to the considerable amount of time, effort, and talent required to develop interpreter skills.

To increase the number of qualified interpreters and to enhance the skills of currently certified interpreters, DARS is seeking to expand and strengthen relations across the state with the interpreter training programs and school districts that provide sign language programs. The long-term goal is to increase awareness about the field of interpreting and to stimulate interest in interpreting as a career.

Proposed Medicaid Rule Changes by Centers for Medicare and Medicaid Services

Significant discussions at the federal level of government are taking place about scope of Medicaid and the relative burdens that state and federal government should shoulder to insure people in poverty and people with disabilities. The Centers for Medicare and Medicaid Services (CMS) has proposed rules that restrict Medicaid funding and could significantly impact state programs that rely on that source of funding; the Early Childhood Intervention (ECI) program is one example. Since federal Medicaid funding for ECI was approximately 25 percent of all ECI funding for FY 2008, the changes present considerable risk to ECI and other state programs that rely on this funding source. The proposed rules affect the types of services that ECI can bill to Medicaid and the scope of administrative claims allowed by ECI providers. Since the rule-changes are not final, it is not certain how these changes would impact ECI, and the fiscal impact may not be known until next year. Meanwhile, the 110th Congress is considering placing a moratorium on seven Medicaid rules issued by CMS, including those affecting DARS ECI.

Strategic Relationship with Workforce System

The Texas Workforce Investment Council (TWIC) serves as the Workforce Investment Act's (WIA) required State Workforce Board in Texas. The DARS Commissioner acts as the Health and Human Services Commission's (HHSC) Executive Commissioner's designee. TWIC, in collaboration with system partner agencies, including HHSC and DARS, has developed *Destination 2010: FY 2004-FY 2009 Strategic Plan for the Texas Workforce Development System*. The plan

establishes a framework for budgeting and operation of the Texas Workforce system. The dynamic nature of the planning process provides for annual evaluations of progress and recommendations for further action. *Destination 2010* is updated annually, to indicate accomplishments and milestones achieved, as well as other applicable changes to the Strategic Action Plans. Certain DARS performance measures—consumers served, employment retention, and number of consumers who entered employment—are included in the TWIC annual report.

Because the Rehabilitation Act appears as Title IV of WIA, there is a direct connection between VR programs and the WIA activities at the state and local workforce levels. This connection emphasizes the importance for DARS and its consumers to work in partnership with TWIC and system partners to share relevant performance data and to foster stronger relationships at the state and local levels.

Strengthening the Statewide Network of Centers for Independent Living in Texas

Independent living services—from ECI to senior services, from vocational placement to community integration—are an integral part of the continuum of assistance essential to persons with disabilities. Independent Living Centers (ILCs) are community-based, non-residential organizations that provide independent living skills training, individual and systems advocacy, peer counseling, and information and referral services to people with significant disabilities. These services help individuals with significant disabilities to live more independently, avoid living in an institution, and where appropriate, obtain employment.

The ILC network plays an important role as a critical link to the service delivery systems of other health and human services programs in local communities. The Centers provide expertise in navigating the array of community services that otherwise may not be discovered by a person with a severe disability. Centers also respond to the local needs of their communities by providing additional, specialized services. Currently there are 23 ILCs in Texas. Still, there remains a great need for services provided by the ILCs across the state. Fewer than half the counties in Texas are served by a center. DARS will request funding for three additional centers in the 81st Legislative Session.

Early Childhood Intervention Disallowance Settlement

In late 2006 CMS disallowed approximately $19 million in federal payments for claims from the ECI program. This disallowance reflected the difference between a previously approved reimbursement method and a later one that ECI had used to submit claims. After negotiations with CMS, the state and federal parties settled the issue for a final disallowance amount of approximately $8 million.

Current Activities by Goal: Target Populations, Service Descriptions, and Trends and Initiatives

DARS Goal 1: Children with Disabilities

DARS will ensure that families with children with disabilities receive quality services enabling their children to reach their developmental goals.

The Texas State Data Center (SDC) and the Health and Human Services System demographers review and analyze both the National Health Interview Survey and the American Community Survey to develop Texas rates for both the Blind Children's Vocational Discovery and Development (BCVDD) program and DHHS. This approach is necessary since Texas does not have a unique source of information for these disabilities.

The National Health Interview Survey provides information from a sample survey at the national level for the percent of the U.S. population that is blind and visually impaired and the percent of the U.S. population that is deaf and hearing impaired. These data are developed by age and race.

The rates that are developed from the National Health Interview Survey are then applied to the Sensory rates that are based on the American Community Survey for the State of Texas. The Sensory rates include both the Blind and Visually Impaired and Deaf and Hearing Impaired combined. By applying the National Health Interview Survey rates to the American Community Survey Rates, demographers are able to develop individual rates for both the Blind and the Visually Impaired and Deaf and Hearing Impaired.

The rate developed by the above analysis for the population of children from birth to 9 years of age is applied to the population projection for that age group to calculate to population in need for the Blind Children's Vocational Discovery and Development (BCVDD) program.

For ECI, the current methodology is essentially a work-load projection. ECI serves children younger than three years of age, and currently, the U.S. Census and the American Community Survey do not collect disability data for the population younger than 5 years of age. Similarly, data are not available on the number of children with "atypical development" or even developmental delays.

Early Childhood Intervention Services

Target Population

ECI services are available to all eligible children and their families. In Texas, children are eligible for comprehensive ECI services if they are younger than three years of age and have any of the following conditions:

- A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay;
- A documented delay in one or more of the following areas of development: cognitive, physical/motor, speech/language, social/emotional, and adaptive/self-help; or
- Atypical development.

Service Description

ECI services include comprehensive services, follow-along services, and respite care. The following array of services is required by IDEA, Part C:

- Assistive technology;
- Audiology;
- Early identification, screening, and assessment;
- Family counseling;
- Family education;
- Health services;
- Home visits;
- Medical services;
- Nursing;
- Nutrition;
- Occupational therapy;
- Physical therapy;
- Psychological services;
- Service coordination;
- Social work services;
- Developmental services;
- Speech language therapy;
- Transportation; and
- Vision services.

Children are referred for early intervention services by family physicians, hospitals, family friends, social workers, day care providers, or others familiar with the child and with early intervention services. After beginning services, families and service providers work together to develop an Individualized Family Service Plan. Family-

centered services are provided to help achieve the goals identified in the plan. Children and their families generally receive services in their natural environments—where children typically learn, live, and play, and where children without disabilities participate in daily activities.

In FY 2007, comprehensive services were provided to 49,359 children with developmental disabilities or delays. Services were provided through 58 community-based programs. These programs include the following kinds of public and private service providers:

- 28 community/state mental health and mental retardation centers;
- 16 private non-profit service organizations;
- 7 regional educational service centers;
- 5 local independent school districts; and
- 2 other agency types.

Blind Services for Children

Target Population

The BCVDD program focuses on services for children from birth through nine years of age. Youth 10 years of age or older are referred to the Division for Blind Services (DBS) Transition Services program. However, the BCVDD program continues to provide services for those children from 10 to 21 years of age who do not meet the eligibility criteria for the Transition Services program. Projected population data for the planning period 2009-13 are listed in Table 7.1 below.

Table 7.1
Service Populations Projections
for Child Blindness and Visual Impairment in Texas

Age	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
0-21	58,355	59,056	59,760	60,398	61,029

Table 7.1: Department of Assistive and Rehabilitative Services, 2007.

Service Description

The BCVDD program provides opportunities for children who are blind or severely visually impaired to increase the skills required for personal independence, potential employment, and other life pursuits.

Specialized services include counseling and guidance for children and their parents regarding adjustment to blindness and the impact of blindness on development, educational support, information and referral, independent living training, and developmental equipment. These services foster vocational discovery and development while promoting the children's self-sufficiency, thereby decreasing the need for services later and giving the children a solid foundation when they enter the world of work. The program's emphasis is on serving children who are permanently and severely visually impaired.

Although the program served 3,221 children in FY 2007, in the past several years, resources for the Blind Children's program have not been sufficient to meet the needs of all eligible consumers. Creative approaches to service delivery have been used to serve clients, but reductions in services still have been necessary. Even with these reductions in services, caseload sizes have remained high. As a result, the BCVDD program is unable to meet all of the unique needs of consumers and their families. DARS received additional funding for the program in FY 2009, to alleviate the high caseload sizes for the current biennium. For the 2010-11 biennium, the agency is requesting additional funding to address expected program growth.

DARS Goal 1 Trends and Initiatives

Trends in the Early Childhood Intervention Services Population

Evidence indicates that the ECI target population has become progressively more complex. More children are being born prematurely and with low birth weight (less than 5.5 pounds) or extremely low birth weight (3.5 pounds). The National Center for Health Statistics (NCHS) birth data for 2005 reflect that the preterm birth rate (the percentage of babies born at less than 37 weeks' gestation) is continuing to rise. In fact, more than 525,000 babies, or 12.7 percent, are born prematurely each year. The preterm birth rate in Texas increased by 21 percent between 1992 and 2002. In an average week, 7,333 babies are born in Texas, with 1,002 babies being born preterm and 589 babies being born low birth weight (NCHS 2003/2004 data.).[2] Prematurity is a major determinant of illness and disability among infants, including developmental delays, chronic respiratory problems, and vision and hearing impairment. However, as a result of early intervention services, many children attain significant and lasting developmental progress and outcomes.

As Texas becomes more racially, ethnically, and culturally diverse, the ECI service system must respond to these changes, to maintain its effectiveness. The percentage of Hispanic children in the birth-to-three age group was approximately 44 percent in 2000, and it increased to 48 percent in 2005. By 2010, it is projected to increase to 52 percent. Similarly, regional differences in population growth rates must be considered in state and local planning efforts. DARS has created a service

[2] NCHS 2003/2004.

delivery system of contractors that serves every Texas county. Each contractor is charged with implementing an outreach plan to identify all eligible children in the contractor's service delivery area. Plans must include activities to inform the public and the referral sources about the importance of early referral. The ECI service delivery system can be adjusted to quickly move resources to areas of increased need.

ECI programs must also be prepared to serve children with specialized needs. These specialized needs include autism, infant mental health concerns, intensive medical needs, and auditory and/or visual impairments. Often these children require more frequent and intensive services. Although some local programs have developed teams of individual service providers who specialize in planning and delivering services to children and families with specialized needs, resource limitations continue to be a statewide concern. Changes in eligibility criteria mandated by the 78th Legislature in 2003, and the implementation of a family cost share for early intervention services, slowed enrollment growth during FY 2004 and the first half of FY 2005.

Table 7.2
Trends in Referrals and Enrollment
in Early Childhood Intervention Comprehensive Services

Fiscal Year	Referrals	Percent Change	Average Monthly Enrollment	Percent Change
2003	45,060	7.6%	20,630	10.2%
2004	46,240	2.6%	20,171	-2.2%
2005	47,845	3.5%	20,950	3.9%
2006	51,288	7.3%	22,238	6.1%
2007	64,836	26.4%	23,639	6.3%

Table 7.2: Department of Assistive and Rehabilitative Services, 2007.

However, enrollment began to increase toward the middle of 2005 and continued increasing during FY 2006 and FY 2007, as indicated in Table 7.2 below. This increase was attributable in part to an increase in referrals as a result of the implementation of the Child Abuse Prevention and Treatment Act (CAPTA) and in part to a reduction of the fees assigned under the family cost share implementation. CAPTA provisions require each child who is younger than 3 years of age and is the

subject of a substantiated case of abuse or neglect, to be referred to ECI for screening and evaluation. The increases in referrals attributable to CAPTA and reflected in FY 2007 are not expected to continue in future years.

Additionally, there are funding implications for the provision of services with a wide range of intensity and frequency. As discussed above, in the Challenges and Opportunities section of this chapter, CMS has proposed rules that will decrease the federal government's financial participation in providing ECI services. While the service needs for some children have increased, the budgeted cost for each child served has not increased significantly over the past several years. The increases have not kept pace with increasing therapist salaries and additional initiatives implemented by ECI. The increasing salaries of therapists and the shortage of therapists who provide the range of services required by IDEA, including, speech, physical, and occupational therapy continue to be a challenge to the ECI program.

DARS will identify additional funding to support working with families who require more frequent and intensive services, and DARS will continue to gather data regarding data on children with high service needs, the shortage of therapists, and service levels and models to serve children with complex needs.

Trends in the Blind Children's Target Population

The number of babies born in the U.S. with severe visual impairments or blindness is increasing.[3] With advances in modern technology, more babies with multiple disabilities are surviving. Additionally, TEA, a primary source of referrals to the program, reports an increase in the number of blind and visually impaired children who receive special education services. From school year 2006 to school year 2007, the number of blind and visually impaired students increased by 204.[4]

These children have complex needs and require a variety of service delivery options. With an average caseload size of 82 permanently and severely visually impaired children, specialists face multiple challenges when delivering the array of services required by these children and their families. Specialists must have comprehensive knowledge of resources, disabilities, interventions, training, assistive technology, and support systems for the families.

DARS Goal 2: Persons with Disabilities

DARS will provide persons with disabilities quality services leading to employment and living independently.

[3] Brigitte Volmer, *et al.*, "Predictors of Long-term Outcome in Very Preterm Infants: Gestational Age Versus Neonatal Cranium Ultrasound," Pediatrics, November 2003.
[4] Texas Education Agency, Registration Report.

VR and independent living (IL) services for adults and youth are available for people with general and visual disabilities. DARS also serves Texans who are deaf or hard of hearing.

Vocational Rehabilitation Services

To determine the service population projections for VR services, demographers calculate a cross-tabulation on the American Community Survey of the population with a sensory disability that has a work disability. The results of the cross-tabulation are then applied to the American Community Survey-National Health Interview Survey adjusted Sensory Disability Rates for the Blind and Vision Impaired population. This rate is applied to the SDC population projection (HHSC selected scenario) to develop the population in need for the Vocational Rehabilitation Program (Blind).

The American Community Survey work disability rate is applied to the Texas SDC population projection HHSC selected scenario and reduced by the population in need for the Vocational Rehabilitation Program (Blind) for the same period to develop the population in need for the Vocational Rehabilitation Program (General).

Vocational Rehabilitation—Blind

Target Population

DBS assists Texas adults and youth who are either blind or significantly visually impaired, to meet their employment and independent living needs. The program offers a variety of skills training, accommodations, and adaptations, which are tailored to each consumer's skills, abilities, and interests. The principle of informed consumer choice guides the provision of services, with the ultimate goal of helping consumers function as independently as possible in employment consistent with their skills, abilities, and interests.

The Texas population growth has a direct impact on the blind and visually impaired population. The number of people potentially eligible for services is estimated to increase by more than 38,000 persons during this planning period. The largest increase is expected in the VR program population, followed by the population of people 65 years of age or older, where the majority of consumers are served by the IL program.

Service Description

The VR—Blind program provides services for eligible individuals, consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. Work-related services are based on individual needs and are geared toward providing eligible adults with the wide range of skills, equipment, and services they need to enter employment, keep their jobs, or return to the workforce after losing their vision.

Some of the available specialized services are listed below:

- Guidance and counseling to assist the consumer and the consumer's family with a plan to reach an employment goal and to live confidently and independently;
- Employment Assistance Services in terms of planning and providing services to prepare a consumer for employment, and assisting a consumer in securing suitable employment;
- Assistive technology to assist with employment or attaining education or training leading to employment;
- Orientation and mobility training to assist with traveling independently in the work and home environment;
- Personal and home care training to ready the consumer for an employment lifestyle;
- Job retention services such as training in adaptive skills and equipment for the consumer to maintain a current job;
- Vocational training to learn job skills as well as training on how to pursue and maintain employment;
- Communication/Braille skills to successfully interact at work and in the community; and
- Intermediary assistance with existing and potential employers.

Empowerment is the key to a consumer's success in employment and living independently. It is critical for the consumer to have a positive attitude, high expectations, and mastery of basic blindness skills. The majority of society believes that blindness severely restricts an individual's capabilities, resulting in the common misconception among employers and others that blind people cannot work or even live independently. The ultimate goal of the rehabilitation program is to help consumers to use all their options and to instill in them the confidence to move ahead with life independently.

Advances in technology have opened many doors in the world of work for people who are blind or visually impaired. As part of its overall consumer training program, DBS maintains an Assistive Technology Unit. This unit evaluates consumer needs and provides the consumer and the VR counselor with recommendations regarding the best equipment to meet the consumer's needs.

To meet the vocational needs for individuals with the most severe disabilities, supported employment services are provided to help consumers obtain competitive employment. Specially-trained job coaches/trainers provide consumers with individualized, ongoing support needed to maintain employment. Program enhancements have been introduced to further promote successful employment for this target population.

The VR counselors work with a variety of sources to ensure that individuals gain the independent living skills, experience, training, and education to reach their employment outcome. The program served 9,630 blind people in FY 2007.

The Transition Services program provides age-appropriate VR services to eligible youths 10 years of age and older. Transition services is an outcome-oriented process promoting movement from school to post-school activities, including secondary education, vocational training, integrated employment (including supported employment), continuing education, independent living, and community participation. This program prepares youth, including those with multiple disabilities, to make informed decisions about their future. Consumers develop appropriate skills to transition from the educational environment to the adult community successfully. The program served 1,648 youth in FY 2007.

The Business Enterprises of Texas (BET) program, authorized under the federal Randolph-Sheppard Act, serves legally blind persons by developing and maintaining business-management opportunities in food-service operations and vending facilities located on public and private properties throughout the state. This program assisted 120 individuals in food service employment in FY 2007. BET continues to receive a large number of applications, which requires the program to increase the number of new food service facilities by two in each year of the next biennium. Additional funds to refurbish existing facilities also are necessary. An important consideration is that the BET program is entirely funded by revenues generated from vending machines on state property; thus, expansion would not require general revenue.

The Criss Cole Rehabilitation Center (CRCC) is the agency's comprehensive rehabilitation facility in Austin, serving blind consumers from Texas and also accepting referrals from other states. Services are typically provided in a residential setting. At the center, consumers receive individualized, intensive training and support in developing the confidence to use various alternative skills and techniques. Training includes courses such as Braille, orientation and mobility, technology, college preparatory classes, preparation for BET skills training, daily living skills, and career guidance. Upon completion of training, consumers return to their communities and use their new skills and confidence to seek employment, enroll in college or vocational training, or pursue other opportunities commensurate with their goals. This program served 687 individuals in FY 2007.

Vocational Rehabilitation-General

Target Population

To be eligible for the VR—General program, an individual must:

- Have a physical or mental impairment that constitutes or results in a substantial impediment to employment;

- Require VR services to prepare for, enter, engage in, or retain gainful employment consistent with the consumer's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice; and
- Be able to get and keep a job after receiving services.

Individuals who receive Social Security Disability Insurance and Supplemental Security Income disability benefits are presumed eligible for VR services.

In FY 2007, more than 93 percent of the consumers served in the VR—General program had significant disabilities. The range of disabilities that had interfered with their employment included:

- 27 percent with musculo-skeletal disabilities;
- 18 percent with mental/emotional disabilities;
- 18 percent with cognitive disabilities;
- 10 percent with deafness or hard of hearing;
- 5 percent with neurological disabilities;
- 4 percent with substance abuse disabilities;
- 3 percent with traumatic brain/spinal cord injuries;
- 2 percent with cardiac/respiratory/circulatory disabilities; and
- 13 percent with a variety of other impairments.

As a result of services provided by the VR-General program, consumers found work in a variety of occupations:

- 21 percent in service industries;
- 17 percent in office and administrative support;
- 17 percent in professional or managerial positions;
- 11 percent in health care related positions;
- 8 percent in transportation and material moving positions;
- 8 percent in construction, maintenance, and repair;
- 8 percent in sales and related positions;
- 7 percent in production related positions;
- 2 percent in protective service and military; and
- 1 percent in farming, fishing, and forestry industries.

Table 7.3
Service Population Projections for Vocational Rehabilitation

Fiscal Year	2009	2010	2011	2012	2013
VR Services—General	959,799	978,818	998,129	1,105,208	1,032,204
VR Services—Blind	89,733	91,511	93,316	94,913	96,502

Table 7.3: Department of Assistive and Rehabilitative Services, 2007.

Service Description

The VR—General program, a state-federal partnership since 1929, helps eligible Texans with disabilities overcome vocational limitations, and it enables them to prepare for, find, and keep jobs. Together, a consumer and a counselor determine an employment goal for the consumer that is consistent with the consumer's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

Work-related services are based on individual needs and may include a variety of services, including the following:

- Medical, psychological, and vocational evaluation to determine the nature and degree of the disability and the consumer's job capabilities;
- Counseling and guidance to help the consumer and the family to plan vocational goals and to help the consumer adjust to the working world;
- Training to learn job skills in trade school, college, university, on the job, or at home;
- Hearing examinations, hearing aids, and other communication equipment, aural rehabilitation, and interpreter services for the deaf and hard of hearing;
- Medical treatment and/or therapy to lessen or remove the disability;
- Assistive devices such as artificial limbs, braces, and wheelchairs to stabilize or improve functioning on the job or at home;
- Rehabilitation technology devices and services to improve job functioning;
- Training in appropriate work behaviors and other skills to meet employer expectations;
- Job placement assistance to find jobs compatible with the person's physical and mental ability;

- Supported employment services; and,
- Follow-up after job placement to ensure job success.

The principle of informed client choice guides the development of the consumer's Individualized Plan for Employment. After the plan is developed, counselors use case service funds to purchase services needed to achieve the employment goal. Counselors have the authority to purchase services for consumers in accordance with federal and state law and department policy.

Despite population growth in Texas over the last several years and the anticipated growth over the planning period, there has been no growth in appropriated full-time equivalent (FTE) positions with Rehabilitation Services. Additional human resources are needed to avoid overly large caseloads where population growth is most acute, with caseloads significantly exceeding generally recognized parameters.

As part of the VR program, counselors across the state provide transition planning services to eligible students with disabilities to assist with the transition from high school to employment or further education. These counselors actively seek students with disabilities who are enrolled in regular and special education, to provide them information about the availability of VR services. Currently, the VR program has 100 positions dedicated to serving transition students within high schools. These Transition Vocational Rehabilitation Counselors (TVRCs) work in approximately 430 predominately 5A and 4A high schools across Texas serving students with disabilities. There are more than 2,100 public high schools in Texas. More TVRCs are needed to serve additional 5A, 4A, and 3A high schools. Due to the special needs of deaf students, there is also a need for specialty deaf counselors to work with the regional day school programs for the deaf. These counselors will be able to provide the communication access the students need to fully participate in their transition planning. Each region also has a Regional Transition Program Specialist available to counselors to facilitate cooperation with local school districts and other state agencies promoting transition-planning services. In Texas, 6,225 students were served during FY 2007.

Comprehensive Rehabilitation Services

Target Population

The CRS target population includes people with TBI and SCI who have experienced a catastrophic injury to the central nervous system, which requires a special set of services.

The current method for calculating service population projections for CRS was developed by a CRS workgroup and utilizes data from population projections by the SDC and the Centers for Disease Control and Prevention (CDC). The methodology uses estimates for the percent of Texans with insurance adequate to cover expenses related to spinal cord and traumatic brain injuries. The CRS program

projects the following numbers of persons potentially needing the program's services.

Table 7.4
Service Population Projections for Comprehensive Rehabilitation Services

Fiscal Year	2009	2010	2011	2012	2013
Service Population	6,675	6,864	7,005	7,148	7,291

Table 7.4: Department of Assistive and Rehabilitative Services, 2007.

Service Description

CRS, developed for people with TBI and SCI, offers inpatient comprehensive medical rehabilitation, outpatient rehabilitation services, and post-acute brain injury rehabilitation services. These services are necessary to increase an individual's ability to function independently within the family and the community. These time-limited services are designed to assist the consumer with daily living skills and to prevent secondary disabilities such as respiratory problems, pressure sores, and urinary tract infections, thereby increasing the consumer's ability to function independently.

The CRS program is financed through a stream of dedicated state general revenue, coming from court costs assessed on misdemeanor and felony convictions. For each year of the current biennium, in addition to the $12.8 million from the dedicated fund, $3.1 million was appropriated to address the CRS waiting list. As the Texas population increases, so does the need for the CRS program. For any given time period, when the number of eligible consumers exceeds available funding, a waiting list is formed. The 80th Legislature provided funding to DARS to reduce the waiting list in the CRS program. If referrals to the CRS program continue at the current rate, some consumers will be waiting for funding at the end of FY 2009. In the last four years, the CRS budget increased by 60 percent. The personnel who work in this program spent an increased amount of time on it, with a corresponding decrease in the time they spent working in the VR program.

Independent Living Services

To determine the service population projections for independent living services, the demographers calculate a cross-tabulation on the American Community Survey of the population with a sensory disability that has a self-care disability. The results of the cross-tabulation are then applied to the American Community Survey-National

Health Interview Survey adjusted Sensory Disability Rates for the Blind and Vision Impaired population. This rate is applied to the Texas SDC population projection (HHSC selected scenario) to develop the population in need for the Independent Living Program (Blind).

The population with a self-care limitation based on the American Community Survey is reduced by the population in need for the Independent Living Program (Blind) to develop the population in need for the Independent Living Program (General).

Independent Living Services—Blind

Target Population

The Independent Living (IL)—Blind program is available to adults of all ages whose independence is threatened because of vision loss. The predominant potential consumer group includes individuals who are older, or no longer able to work, and who are experiencing serious limitations in their functional capacities because of severe visual loss. To the extent that Texans who are blind or visually impaired are independent within their homes and communities, the need for publicly funded nursing care and assisted living is reduced. Likewise, blind individuals who have returned to the community from institutional settings find the adjustment and adaptive techniques offered by this program beneficial.

Projected prevalence rates for the IL—Blind program are included in Table 7.3. Projections are based on Texas data from respondents who describe themselves as having a serious vision loss, and who have difficulty in areas of self-care (e.g. dressing, bathing, or getting around inside the home). Even with these modified projections, the IL program continues to struggle to meet the needs of this ever-growing target population.

Service Description

The IL—Blind program offers specialized services to help people avoid institutionalization and remain in the community. Services build confidence in living independently, primarily through adjustment to blindness and learning alternate ways to do daily tasks. A variety of services address the amount and kind of assistance needed, including:

- Information about vision loss, adjustment to blindness, adaptive techniques, and special resources related to vision loss;
- Referral to other community resources related to aging, disability, and other individualized concerns;
- Group training to encourage self-confidence building experiences and to provide opportunities for “hands-on” application of adaptive techniques for everyday activities;
- One-on-one, in-home adaptive skills training; and
- Peer support development.

In FY 2007, 3,337 people were served in this program. DBS continues to be challenged by the disparity between the growing population of older people and limited program resources. Historically, the program has reached fewer than 2 percent of the population projected to be experiencing serious loss of vision. This is consistent with national trends. To maximize resources, DBS continues to focus on service delivery approaches that most effectively match consumer needs.

Independent Living Services—General

Target Population

IL consumers have significant disabilities resulting in a substantial impediment to their ability to function independently in the family and/or in the community. These individuals face barriers that severely limit their choices for quality of life. Some barriers are obvious, such as a curb with no ramp for people who use wheelchairs or a lack of interpreters or captioning for people with hearing impairments. Other barriers are often less obvious and can be even more limiting, such as inadequate or inaccessible housing, attendant care, or transportation. Unfortunately, misunderstandings about disability can prevent people with disabilities from living independent lives in their communities.

IL services contribute to the independence of people with disabilities in the community and support for their movement from nursing homes and other institutions to community-based settings.

The Texas population is growing, aging, and living longer, creating increasing needs for rehabilitation, and increasing the demand for IL services. The number of applicants to the IL services program is steadily increasing. The cost of services, especially for medical services, is increasing significantly each year and straining program resources. Assistive technology, which enables consumers to live independently, is becoming more sophisticated in addressing more kinds of functional needs. At the same time, it is also becoming more expensive. As a result of these trends, funding for the IL services program has not been equal to the demand, and a waiting list has resulted.

The 80th Legislature appropriated $0.6 million for the 2008-09 biennium to DARS to prevent growth of the IL services waiting list. Since these funds are to prevent future growth, but not to eliminate the waiting list, there will continue to be consumers waiting for purchased services.

Table 7.5
Service Population Projections for Independent Living Services

Fiscal Year	2009	2010	2011	2012	2013
IL Services—General Population	679,300	695,400	711,200	732,500	754,300
IL Services—Blind	119,000	121,800	124,600	128,300	132,200

Table 7.5: Department of Assistive and Rehabilitative Services, 2007.

Service Description

The IL Services—General and ILCs provide a broad array of services promoting increased self-sufficiency and enhanced quality of life for persons with significant disabilities. With assistance from IL Services—General, people with disabilities become more independent within their communities. Examples of IL services include counseling and guidance, durable medical equipment, communications aids, prostheses, rehabilitation technology, and IL skills training.

Consumers control the decision-making, service delivery, and management of community-based ILCs, promoting practices that increase self-help, strengthen self-advocacy, and actively develop peer relationships and role models. Core ILC services include information and referral, IL skills training, peer counseling, and individual and systems advocacy.

Blindness Education, Screening, and Treatment

Target Population

The Blindness Education, Screening, and Treatment (BEST) program target population includes adult Texans who may be at risk for blindness because of untreated eye medical conditions such as diabetic retinopathy, glaucoma, and detached retina.

Service Description

Created in 1997, the BEST program is designed to prevent blindness. Program functions involve two major activities:

- The provision of adult vision screening services to identify conditions that may cause blindness, and
- Payment for urgently needed eye medical treatment for adults who do not have health insurance or other resources to pay for the needed treatment.

The BEST program is supported by Texans who donate a dollar when they renew their driver license or Texas Department of Public Safety-issued identification card. In FY 2007, 8,361 individuals received vision screenings, and 253 received eye medical treatment.

BEST services are designed to reduce the number of Texans who lose their sight. By encouraging Texans to take care of their eyes and seek professional care if they are at risk for potentially serious eye conditions, and by assisting with medical treatment to prevent blindness, BEST helps Texans retain employment and support their families while saving federal and/or state funds that would otherwise be needed for rehabilitation and/or social services if blindness occurred. Further, because the program's sole source of funding is voluntary donations, the BEST program provides critically important services without requiring the use of federal or state resources.

Deaf and Hard of Hearing Services

Target Population

DARS serves Texans who are deaf or severely hard of hearing. DARS estimates that there are more than 756,000 persons in Texas who are deaf or severely hard of hearing or 3.1 percent of the population.[5]

The greater the extent and the earlier the onset of hearing loss, the greater the likelihood persons are to need and seek services. DARS projects the following prevalence data for the planning time period.

Table 7.6
Projections of Deaf and Hard of Hearing in Texas

Fiscal Year	2009	2010	2011	2012	2013
Deaf or Hard of Hearing	763,755	778,275	793,081	808,173	823,535

Table 7.6: Department of Assistive and Rehabilitative Services, 2007.

[5] "Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2005." U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, and the American Community Survey, 2006.

Service Description

The DHHS office at DARS promotes and regulates an effective system of services for individuals who are deaf or hard of hearing, and it evaluates and certifies interpreters. To facilitate the provision of specialized services to individuals who are deaf or hard of hearing, DARS contracts with community-based organizations that provide communication access and other services designed to remove barriers between individuals needing services and service providers in the communities. Such services include:

- Advocacy services;
- Outreach and education services;
- Interpreter services;
- Adjustment and hearing technology services for persons experiencing hearing loss;
- Computer assisted real-time transcription (CART) services;
- Interpreter training, including Hispanic trilingual training;
- Service provider training regarding the provision of services to individuals who are deaf or hard of hearing;
- Information and referral services;
- Vocational education and independent living services for individuals who are low-functioning deaf or hard of hearing; and
- Services to older persons to bridge communication barriers and reduce isolation.

DARS certifies interpreters of varying levels of skill and maintains lists of certified interpreters for courts, schools, service providers, and other interested entities. There are currently 1,635 certified interpreters in the state. DARS has developed new interpreter certification tests to replace tests that had been used for 25 years. The new tests are valid and reliable. Highly skilled and certified interpreters are contracted to score the tests and determine the skill levels of individual candidates. Most interpreting situations require advanced skills, and only 669 interpreters are certified at advanced levels. At least one-third of this higher certification group are working in administrative or teaching functions and not readily available for interpreting. Only 166 of all certified interpreters are certified by DARS for interpreting in court. Additionally, Hispanic trilingual interpreter tests are being developed. The implications are discussed in the Trends and Initiatives section below.

DARS also administers the Specialized Telecommunication Assistance Program, authorized by the 75th Legislature. This voucher program, funded by the Universal Service Fund, provides telecommunication access equipment for persons who are deaf or hard of hearing, speech impaired, or who have any other disability that interferes with telephone access. During FY 2007, more than 25,600 vouchers were issued, of which 87 percent were for amplified telephones.

DARS Goal 3: Disability Determination

DARS will enhance service to persons with disabilities by achieving accuracy and timeliness within the Social Security Administration Disability Program guidelines and improving the cost-effectiveness of the decision-making process in the disability determination services.

Disability Determination Services

Target Population

For Social Security purposes, disability means a medical condition preventing a person from working, or in the case of a child, preventing the child from engaging in age-appropriate activities. The medical condition must be so severe that it will last at least 12 continuous months or result in death, and it must be documented by objective medical evidence.

Disability Determination Services (DDS) administers two disability programs on behalf of the Social Security Administration (SSA). The first program, Social Security Disability Insurance (SSDI), is related to work. Workers earn coverage for themselves and family members by paying Social Security tax. The program covers workers who have a disability, widows/widowers who have a disability, and workers' adult children who have a disability.

The second program, Supplemental Security Income (SSI), is related to means—what a person earns and owns. People who meet the criteria for disability and have low incomes and few assets may qualify for SSI benefits, which supplement SSDI benefits.

Service Description

When a person is not able to work due to a physical or mental impairment, that person may apply for federal SSDI and/or SSI disability benefits. By agreement between the state and SSA, DDS processes the applications for these benefits. SSA provides 100 percent of the funding for the DDS.

Each application for SSDI/SSI disability benefits originates in an SSA field office and is forwarded to DDS. There it is developed and adjudicated by a trained claims examiner who reviews the disability forms and gathers medical evidence from the claimant's treating sources. Usually the examiner receives enough evidence from the applicant's medical sources to make a decision. If more evidence is needed, a consultative examination is arranged and paid for by DDS, with funds from SSA.

The examiner and a medical consultant together review all the information and determine whether an applicant is disabled as defined by SSA. In federal fiscal year (FFY) 2007, DDS processed 190,802 initial cases, determining that 77,807 people, or 41.7 percent, met the SSA criteria for disability. For quality control, SSA reviews

a sample of initial DDS determinations. In FFY 2007, the DDS achieved a 95.9 percent accuracy rate, while the national average rate was 93.8 percent. After completion of the DDS adjudication process, the case is returned to the local Social Security office, and the applicant is notified of the decision by mail. In FFY 2007, the Texas DDS average processing time for an initial case was 66.6 days, while the national average was 84.2 days.

Applicants who have been denied benefits may request reconsideration, the first step in the appeals process. Reconsideration cases are reviewed in DDS by a different examiner and doctor from those who processed the initial application. In FFY 2007, DDS reviewed 47,902 reconsideration cases, of which 9,236, or 19.6 percent, were allowed, meaning that the initial decision to deny benefits was reversed.

The DDS allowance rates for both initial and reconsideration cases were higher than the national average in FFY 2007. The national allowance rate for initial cases was 34.6 percent, and for reconsideration cases, it was 12.7 percent. This means that, in percentage terms, the Texas DDS determined claimants to be “disabled” at a rate above the national average. SSA has final authority to award or deny benefits.

SSA reports that in December 2005, 378,720 Texans with disabilities were receiving an average monthly SSDI benefit check of $924. At that time, there were also 391,939 Texans receiving SSI disability/blind benefits at the rate of $412 each month. In some instances a person with a disability was receiving both SSDI and SSI benefits, and the numbers reported reflect unduplicated beneficiary counts within each program.

DARS Goal 3 Trends and Initiatives

Increase in Disability Applications

The most significant trend impacting DDS continues to be the increase in the number of SSA disability claims expected due to population growth and the aging of the baby boomers. As the population grows, so does the total number of disability claims filed. Further, as aging baby boomers reach a more vulnerable stage in life, they will likely apply for disability benefits in increasing numbers.

In a report published by the U.S. Government Accountability Office (GAO-03-117), SSA predicts that by 2010, an increase of 32 percent will occur in disability applications over year 2000 levels. If DDS case processing efforts are to meet this increased need, SSA will have to provide increased funding. The SSA projects the following caseloads for DDS in the planning time period.

Table 7.7
SSA Projected Caseload for Texas Disability Determination Services

Federal Fiscal Year	2007 (actual)	2008	2009	2010	2011
Estimated Cases That Will Be Processed	268,043	281,177	289,612	298,301	307,250

Table 7.7: Social Security Administration, 2008.

Turnover

DDS workforce losses are a significant trend. It generally takes from two to three years for a disability examiner to become fully proficient in the job. As greater numbers of examiners retire or seek employment elsewhere in higher-paying jobs, the impact on the workforce will be significant. In the report "Better Planning, Management, and Evaluation Could Help Address Backlogs" (GAO-08-40) the GAO noted that the attrition rate for state DDS disability examiners is almost double that of SSA federal staff. Currently, 37.7 percent of the examiners in Texas have less than three years' experience. In Strategic Workforce Planning Needed to Address Human Capital Challenges Facing the Disability Determination Services (GAO-04-121), GAO cited three challenges in retaining disability examiners:

- High turnover, with stressful workloads and noncompetitive salaries cited as contributing factors;
- Difficulties in recruiting and hiring; and
- Gaps in key skills, requiring additional training in critical areas.

For the DDS to maintain operations, these challenges must be met.

New Initiatives

SSA has two significant initiatives underway which impact the way DDS does business. The first was launched several years ago and is now coming to completion. This initiative involves changing from paper disability claims folders to electronic files. In December 2005, the Texas DDS became certified to process initial claims electronically. Since then, the conversion from paper to electronic has been almost completed, because the vast majority of all initial and reconsideration claims are handled electronically. Continuing disability review (CDR) claims, re-reviews of people currently receiving disability benefits, will soon switch from paper to electronic. Additionally, great strides have been made in securing medical

evidence in electronic format, thus eliminating the need to scan paper medical reports into the electronic folder.

The second initiative by SSA is the implementation of the Quick Disability Determination (QDD) process. QDD allows SSA to screen all disability claims before transmitting them to DDS, searching for medical conditions that are more than likely to result in an allowance. When such a medical condition is noted, the case is identified as a QDD and processed expeditiously by DDS. This assures that those persons in critical need receive a prompt determination.

DARS Internal Assessment

This section represents an evaluation of the key internal factors that influence DARS. Below is a discussion of the agency's internal processes and operations, its perceived strengths and challenges.

DARS Internal Processes/Operations

Disability Specialist (DS) Reclassification

As discussed above, DDS is funded entirely through SSA, to make disability determinations for Texans who apply for SSDI and/or SSI. In order to recruit and maintain a well-qualified workforce of disability specialists at DDS, the current state disability specialist position needs to be re-classified for consistency with the federal job descriptions SSA has provided for the Disability Specialist position. SSA has written these descriptions and provided them to each state for their use, due to the unique requirements of a DS. Ensuring consistent job classifications within all DDSs, to include pay levels equal to that of the national DS position, will assist in efforts to retain or recruit staff.

Capital Budget

DARS identifies one capital budget item for the strategic planning period: the CCRC Building Maintenance. In order to maintain a safe and functional work environment, the aging CCRC requires continuing repairs and enhancements to the infrastructure of the facility. Insufficient investment in needed repair and maintenance could result in the failure of building functions such as water, wastewater, electrical power, and residential heating and cooling; such failures would prevent CCRC staff from carrying out the training functions for consumers and would possibly displace residents. Repairs and system enhancements at CCRC focused on restoring and improving functions, as well as energy-saving features that will enable DARS to recover the costs of the projects over future periods of time.

Without specific targeted appropriations for these types of expenses, existing maintenance budgets will need to be tapped to ensure that the facility remains operational and that adequate space is available for staff to carry out their assigned responsibilities. DARS must continue to repair its facilities to accommodate the diverse needs of our consumers. Therefore, the department will seek funding to support these initiatives.

Funding for the 2010-11 biennium will address the ongoing maintenance needs of the CCRC and will continue the progress achieved during the 2008-09 biennium.

DARS Internal Strengths and Challenges

Continued Internal Alignment

Within DARS, the Division for Rehabilitation Services (DRS) and DBS both operate VR and IL programs under the federal Rehabilitation Act. Since consolidation, progress has been made to bring the operations of the two divisions into alignment. Still, opportunities remain for alignment of operations across DARS. DARS has completed a number of policy or operational moves since February 2004 to leverage resources and opportunities by eliminating procedural obstacles, streamlining and combining processes when feasible and appropriate. Internal alignment is also vital with regard to provider relations. If two DARS program areas with essentially the same mission reimburse differently for the same service, providers can become confused and, in the worst case, discontinue business with one or both of the program areas. This is especially problematic in the limited population of qualified providers of VR and IL services.

A continual exploration of operational procedures and policies for internal alignment is important for maximizing resources. This requires discussion to determine why processes may be duplicative and if consolidation of these processes is beneficial ensuring that even small details are considered. Prior to undertaking further alignment activities, a careful examination of the benefits of alignment versus the cost in time and resources need to be made. And, it must be considered that although the programs exist under the same federal statute, they are not always similar due to the differing needs of the populations served.

DARS will continue to monitor operations and recognize opportunities for continued improvement of policy and procedure. DARS executive management will review and authorize projects as appropriate to further align policy and procedure.

Medicaid Infrastructure Grant

The DARS Medicaid Infrastructure Grant (MIG) program, in collaboration with HHSC, is developing the infrastructure for a comprehensive system of competitive employment support for persons with disabilities.

This program, administered by CMS, was created by the Ticket to Work and Work Incentives Improvement Act of 1999, with a minimum grant of $500,000 available for qualifying states through 2011. The primary purpose is to provide planning funds dedicated to systems change activities that identify and create a sustainable and engaged infrastructure promoting competitive employment opportunities for people with disabilities. Stakeholder input and measurable outcomes are key components in development and analysis.

The primary grant goals for the first year are:

- Increase enrollment in Medicaid Buy-In (MBI). Funds from the grant will support the implementation of the statewide MBI program by establishing a baseline utilization rate of the MBI and setting goals to increase enrollment through education and outreach.
- Conduct mapping and analysis of system resources. In mapping and analysis of system resources, DARS will analyze public and private resources to assist people with disabilities. To guide in strategically planning for the future, DARS will develop and implement a system to track individuals with disabilities who use the workforce system, and DARS will conduct a gap analysis.
- Increase partner collaboration. Grant funds will be used to implement a tracking model for users of VR and One-Stop workforce systems. Training materials, including a resource guide on programs for people with disabilities, will be developed, and cross-training on MBI will be conducted. A MIG Task Force will be created to enhance information-gathering, collaboration, and use of state resources. DARS will also convene meetings to work toward collaboration.
- Facilitate the establishment of an informed consumer base. Grant funds will be used to develop and market media products to inform consumers about MBI and employment. The resource guide will be a useful tool to help this population navigate through the range of services available at both the state and local level, and it will be distributed statewide.
- Facilitate the establishment of an informed employer base. DARS will concentrate efforts in the area of system capabilities and examination of baseline use data, as well as the development of institutional knowledge, to increase system utilization.

The first operational year of the grant is 2008. Future goals will be developed based on the outcomes achieved in the first year of the project. Emphasis is placed on analysis, development, and implementation. All staff and financial resources are covered in the Medicaid Infrastructure Grant award. Depending on progress after development and implementation of objectives in the first year, additional grant-funded staff may need to be added to achieve broader outcomes in future years.

Many consumers who receive Medicaid benefits are hesitant to earn amounts greater than the Medicaid income limits; given this concern, these consumers could

truly benefit from work incentives such as the MBI. This grant is another example of how DARS works with its consumers to ensure their independence through employment.

Autism Services for Children 3-8

The numbers of children with Autism Spectrum Disorder (ASD) are increasing dramatically. According to data released in 2007 by the CDC's Autism and Developmental Disabilities Monitoring Network, one in every 150 eight-year-old children throughout the U.S. had an ASD diagnosis. Thus, the rate of ASD in children is higher than the rates for Down syndrome (1 in 800 births), juvenile diabetes (approximately 1 in 400 to 500 children and adolescents), and childhood cancer (1.5 per 10,000), according to the National Cancer Institute. Although there is no cure, early intensive behavioral interventions can remedy specific symptoms and can bring about substantial improvement. The ideal treatment plan coordinates interventions that target the core symptoms of autism: impaired social interaction, problems with verbal and nonverbal communication, and obsessive or repetitive routines and interests. Most professionals agree that the earlier the intervention, the better.

In 2007, the Governor's Office and the Legislative Budget Board authorized HHSC to allot $5 million to implement autism services for children from three to eight years of age. DARS was directed to pilot services such as Applied Behavior Analysis and other Positive Behavioral Support strategies for children in this age range with autism. The program is intended to complement services outlined in a child's Individualized Education Plan, if a plan exists, and to bill Medicaid, Children's Health Insurance Program (CHIP), private insurance, and any other available third party source before using DARS funding.

The funding will provide for the services through August 2009. DARS' base legislative appropriations request for the 2010-11 biennium includes continued funding for autism services. In March, 2008, DARS awarded contracts to four autism providers, and service delivery began on April 1, 2008. The future of autism services at DARS will depend on the direction the legislature takes in light of pilot results and other funding priorities.

DDS Out-of-State Travel

Currently, DDS must adhere to state-imposed limits on out-of-state travel costs. These limits hinder many activities that SSA expects the Texas DDS to participate in activities involving state DDSs around the country. Travel to many out-of-state SSA-sponsored meetings is routine. To accommodate SSA and participate in DDS functions, DARS will seek an exemption from the travel cap during the 81st Legislature. Since SSA provides 100 percent of the financial support to DDS, including payment for all out-of-state travel expenses, there is no financial impact for the state.

Chapter VIII

Department of Family and Protective Services External/Internal Assessment

The Department of Family and Protective Services (DFPS) is responsible for administering a variety of protective, regulatory, and prevention programs including Child Protective Services (CPS), Adult Protective Services (APS), Child Care Licensing (CCL) and Prevention and Early Intervention (PEI).

DFPS has its origins in several legacy agencies. The Texas Department of Protective and Regulatory Services (DPRS) was originally created out of the Texas Department of Human Services in 1991 by the 72nd Legislature to protect children and adults who are elderly or have disabilities from abuse, neglect, and exploitation.

The PEI division was created and added to DPRS by the passage of Senate Bill (S.B.) 1574, 76th Legislature, Regular Session, 1999. House Bill 2292, 78th Legislature, Regular Session, 2003, mandated the health and human services reorganization, and DPRS was renamed DFPS.

Recent years have seen significant growth, improvement, and innovation within the agency. During the 79th Legislature, Regular Session, 2005, DFPS was given an unprecedented increase in resource for the 2006-07 biennium, and legislation was enacted that created far-reaching changes to the CPS, APS, CCL, and PEI programs. S.B. 6, 79th Legislature, Regular Session, 2005, contained sweeping programmatic changes to strengthen investigations of child abuse and neglect, better regulate the child care industry, and improve the services provided by APS to vulnerable adults. Among the innovative strategies to reform DFPS were provisions for outsourcing substitute care and case management services, providing medical passports for physical and behavioral health care for children in foster care, and equipping casework staff with mobile tablet personal computers (tablet PCs).

Following two years of comprehensive agency reform, the 80th Legislature, Regular Session, 2007, continued its support of ongoing improvements of DFPS. Additional resources were provided to further reforms in the CPS program, especially around family-centered practices, efforts to address neglect caused primarily by poverty-related factors, and improved accountability in contracted residential care.

After several years of reform, DFPS has largely implemented the original externally mandated improvements. It now has a management infrastructure to evaluate the results of reform, to develop internal and external accountability, and strengthen its program for better client outcomes. This continuous improvement is the basis for major initiatives that will provide the strategic focus for DFPS for the next several years.

The material in this chapter is arranged as follows:

- Challenges and Opportunities,
- Current Activities by Goal:
    - Target Populations,
    - Service Descriptions, and
    - Trends and Initiatives; and
- Internal Assessment.

Challenges and Opportunities

Adult Protective Services

APS is responsible for protecting vulnerable elders and persons with disabilities who reside in Texas. The In-Home program investigates abuse, neglect, and/or exploitation of elder adults (defined as 65 years of age or older) and adults with disabilities who reside in the community. As appropriate, caseworkers provide or arrange for protective services, which may include referral to other programs, transportation, and emergency assistance with food, shelter, and medical care.

The Facilities Investigations program investigates reports of abuse, neglect, and/or exploitation of clients receiving services in state-operated facilities. This program serves adults and children with mental illness or mental retardation living in mental health (MH) and mental retardation (MR) facilities (state hospitals, state schools, and state centers) and/or state contracted settings (intermediate care facilities for persons with mental retardation, home and community-based services programs, and the Texas Home Living Waiver Program).

As part of agency reform, between 2003 and 2007 APS underwent substantial internal improvements. The program completely revised its staff training and development to increase caseworkers' knowledge and skills and to improve case decisions and client outcomes. The APS Guardianship program was transferred to the Department of Aging and Disability Services to eliminate conflict of interest and enable APS to focus on investigating and serving adults in need of protection. Additional staff resources and technological innovations were brought to increase

caseworker efficiency and lower caseloads, both allowing more substantive time to be spend with clients. New client risk assessment, performance management, and community engagement practices were put into place.

By 2040, the Texas State Data Center estimates a 295 percent increase in the number of persons 65 years of age or older. This increase in the elderly population will result in increased demand for APS services. Without additional investment, the existing infrastructure for community-based long-term care and services will not meet the future needs of a growing elderly population with. Adequate infrastructure is necessary to provide ongoing support to clients after short-term interventions by APS.

Further, as federal, state, and local resources for social services programs have declined in recent years, APS has increasingly become a safety net for many adults who are elderly or have disabilities. Many APS clients have fallen into a state of abuse, neglect, and exploitation because other social services programs have exhausted funding, have eliminated or reduced programs, or have lengthy interest lists.

There are significant opportunities to build on the strengths of reform of the APS program. As earlier reform efforts focused on the APS In-Home program, leadership is now engaging in a comprehensive look to the Facility Investigations program. APS continues to assess its program operations and policies to identify additional opportunities for improvement. Quality assurance and performance management systems continue to evolve and are being improved. A formal evaluation of the benefits and challenges of the reform efforts to date is in progress and will serve as a guide to future program direction.

Child Care Licensing

The CCL program is responsible for protecting the health, safety, and well-being of children who attend or reside in regulated child care facilities and homes. CCL develops minimum standards for regulated facilities and homes and the policies and procedures for enforcing those minimum standards. CCL has the additional role of providing consultation, technical assistance, and training for child care providers and educating the public in the selection and improvement of child care services.

In recent years, there have been significant changes to the residential component of the CCL program. The Legislature made a significant investment in the program by funding additional positions to conduct random-sample monitoring inspections of foster homes verified by child-placing agencies. The CCL program revised minimum standards for residential child care facilities and child-placing agencies, many of which had not been revisited in more than two decades. The update and consolidation of residential standards, which went into effect in 2007, strengthened the level of protection for all children in out-of-home care. Due to the significant statutory changes, CCL worked with more than 900 providers to ensure that the

changes were thoroughly understood and appropriately integrated into the provider operations.

CCL increased the professional requirements of administrators in child-placing agencies and revised reporting expectations of serious incidents involving children in placement. CCL made significant enhancements to policy regarding background checks for employees of child care facilities, including a requirement for day care directors and caregivers to have a fingerprint check through the Federal Bureau of Investigation as part of the regular background check process. New rules for drug-testing in residential child care operations were adopted, and the program developed a weighted enforcement structure that assisted staff with consistent decision-making.

As it does with all DFPS programs, the growth of the state's population presents challenges to CCL. The capacity and utilization of licensed child care will continue to increase. Building on the earlier efforts, significant opportunities exist to increase support of the delivery of quality residential and day care child services by licensed providers and to increase internal accountability through improved licensing processes, policy structure, and technology usage.

Child Protective Services

CPS is responsible for ensuring the safety, permanency, and well-being of Texas children who have been maltreated. CPS conducts investigations of abuse and neglect, works with families to create a safe environment for children, and assumes conservatorship of children when they must be removed from their home and placed with substitute families, relatives, or caregivers. The last three years and two legislative sessions have been a time of profound reform and change within the CPS program. Thousands of new employees have been hired as a result of resources provided during the 79th Legislative session. New processes were implemented to improve screening of CPS caseworker job applicants and to prepare them through classroom and on-the-job training.

Significant new resources have been expended to strengthen CPS investigations. CPS developed a new investigation model, which includes a stronger risk assessment instrument, new screening procedures for lower priority cases, and training to recognize and respond to high-risk cases. The Center for Program Coordination hired more than 200 special investigators and 50 child safety specialist staff to assist with CPS investigations and training. Stipends were put in place to attract and keep staff in investigative roles. Training was expanded for CPS caseworkers to include working with law enforcement, conducting forensic investigations, gathering evidence, upholding Fourth Amendment rights, drafting affidavits, and testifying in court. Investigative responsiveness was increased, with tighter timeframes for first response and documentation on CPS cases.

With a renewed focus on family solutions, and as an alternative to paid foster care, CPS has increased kinship placements for children who must be removed from their homes. CPS now offers a comprehensive program that provides financial assistance, child care resources, and additional support to relatives who care for children in the state's conservatorship. Policy and structural changes have formalized the inclusion of families as critical decision-makers regarding child safety and well-being.

An innovative managed care model is being developed to deliver quality health care services geared to specific needs of children in foster care. This model will become active in 2008. Through a competitive procurement process, a contract has been awarded for a comprehensive medical, behavioral health, and dental managed care network for children in foster care. The goals are to ensure better accountability for health care outcomes and to track children's health care as the children move from one placement to another. Youth younger than 21 years of age who are aging out of foster care are now provided with continuous Medicaid coverage through a single application process.

Resources are being deployed towards better educational outcomes for children. Education portfolios for school-age children in care ensure that school records follow each child through placement changes.

CPS worked with community partners to develop pilot programs across the state to address the disproportionate representation of African American children and other children of color in the CPS system and specifically in foster care. The program also added resource and external relations specialists in each region to focus on enhanced service and professional community collaborations.

To increase field casework time with clients and to support caseworker mobility, CPS provided all caseworkers in CPS investigations and Family Based Safety Services (FBSS) programs with tablet PCs and new software.

Increased resources for the CPS program increased expectations of accountability from state leadership. Accountability expectations also exist at the federal level. The United States Department of Health and Human Services, through its Administration for Children and Families (ACF), periodically reviews state performance in the areas of safety, permanency, and well-being, and ACF examines systemic aspects of state child welfare services. The ACF review provides the opportunity for CPS to continuously assess services and make adjustments to improve performance. The last report was released in 2002. CPS developed several initiatives to improve performance based on the review findings. The next ACF service review is occurring during calendar year 2008 and will provide new opportunities for systemic program improvement.

Significant opportunities also exist to build on the reforms of the last few years, and these are detailed in the Trends and Initiatives section of this chapter.

Prevention and Early Intervention/Purchased Client Services

The PEI division manages community-based programs that prevent delinquency, abuse, neglect, and exploitation of Texas children, by contracting for services that protect children, strengthen families, promote positive youth development, and reduce the likelihood of involvement in the child welfare or juvenile justice systems. PEI programs can be classified into three general categories of programs addressing:

- Child maltreatment,
- Juvenile delinquency, and
- Both child maltreatment and juvenile delinquency.

In addition to managing the program and related contracts for PEI services, the Purchased Client Services (PCS) division also administers contracts for CPS and APS clients. PCS procures, manages, and supports effective services, and the division administers prevention programs for DFPS to ensure positive outcomes for clients and partners.

It is essential that contractors are held accountable and that DFPS has a solid contracting infrastructure that provides support for effective management of the contract lifecycle. Contracting improvements are being made in each type of contracted services.

DFPS was given an opportunity by the 79th Legislature to develop a system for the competitive procurement of evidence-based at-risk prevention services. DFPS defines “evidence-based” to include “initial evidence,” which is used in the procurement process to establish whether a proposed plan of service is likely to succeed in achieving the desired client outcomes. It also requires “ongoing evidence,” which requires a provider’s documented success in meeting the client outcome performance measures established for a PEI program contract. This system of procurement moves DFPS further in the direction of performance-based contracting. DFPS increasingly has contracted for evidence-based services proven to be effective in preventing child maltreatment or juvenile delinquency.

Where possible, PCS has worked to convert open enrollment to competitive procurement contracting. Contract staff identify needed service contract improvements related to specific goals, outcomes, and output measures, and these measures became part of future procurements and resulting contracts.

Residential contract monitoring was enhanced to include assessment of the contractor’s ability to meet measures. DFPS increased the depth and scope of monitoring for contractors identified as high-risk due to performance issues. This increase includes issuing provisional contracts to ensure contractors are apprised of areas requiring improvement, engaging in more frequent on-site monitoring of

contractors' corrective actions, and documenting procedures to assist with achieving increased consistency in contracting practices.

For all DFPS programs, there are significant challenges in finding sufficient skilled contactors to deliver needed services. This has been very apparent over the last year as DFPS has worked to find adequate and appropriate placements for some of the highest-need children in CPS care. The root of this challenge is the fact that the number of foster children is growing faster than the capacity of the homes and facilities that care for foster children. Similar challenges exist with the purchase of service contracts for evaluation and treatment, and with prevention and early intervention efforts.

Future strategic opportunities exist in leveraging technology which will streamline the contracting process and increase the availability of performance data. The PCD caseworkers in the CPS investigations and FBSS programs S division is developing a contract management data system to enhance residential contractor accountability.

Agency-Wide Challenges and Opportunities

The following areas pose significant challenges and opportunities across all program areas and have important implications for client services in the future.

Workforce Support and Retention

DFPS has made tremendous improvements in its ability to recruit, hire, and train new staff. Sustaining increased staffing levels is ultimately expected to result in lower caseload levels, less turnover, greater retention of a more professional workforce, and more effective service delivery. The challenge for DFPS has been to recruit, hire, and train enough staff to fill both vacancies and new positions provided by APS and CPS reform. In the short term, retaining existing staff remains a significant challenge and may be the most significant factor impacting the department's ability to deliver quality services. Most agency programs are currently experiencing high turnover rates. It is resource intensive to replace an existing employee and it takes a significant amount of time to develop new staff to the level of competency of tenured employees.

The challenge in retaining staff has its roots in several areas. The work of DFPS staff, particularly the vast majority of those placed in field offices, is emotional, difficult, and often crisis-driven. It requires staff to interact regularly with vulnerable children and adults in dire need and with those who may be or are maltreating them. Workload issues can often exhaust staff. Community expectations of DFPS staff can be great, and sometimes unrealistic. In short, it is a difficult job.

Pay differentials with competing employers are another factor contributing to staff turnover. Teaching, other social service agencies, and federal employment have provided higher wages than and less stressful work for many former DFPS staff. In some cases, the work environment is an issue. DFPS infrastructure has not always kept pace with the growth and expansion of the agency. Existing state processes for procuring office space, for example, can be time-consuming and can lead to multiple employees sharing single offices. Another challenge is that due to high turnover, some current supervisors are not as experienced as past supervisors have been.

Despite significant improvements and enhancements to basic job skills preparation, many staff report feeling unprepared when they enter the DFPS workforce. The complexity of DFPS programs can make it challenging to fully prepare all staff for their field roles in a few weeks of training. This difficulty is compounded with an increase in specialty positions. CPS has hired staff with expertise in substance abuse, law enforcement, forensics, foster care, and medical care, and the program has hired paraprofessionals to assist with client transportation and scheduling. APS has added specialists to address self-neglect, financial exploitation, and other evidence-driven cases. These workers are often tenured employees, and their promotion creates vacancies at the caseworker and supervisor levels.

DFPS continues to concentrate on improving factors that influence turnover rates:

- Reducing caseload levels;
- Hiring employees who have the necessary qualifications, skills, and aptitude to be successful;
- Providing specialized training and supporting new staff in the field;
- Providing opportunities for career development and advancement; and
- Rewarding employees for outstanding performance.

These efforts will be detailed further in this document.

Capacity of Services to Meet the Needs of DFPS Clients

Most DFPS programs continue to experience an increase in the long-term demand for services. Growth over the past few years in the number of reports to the agency may be the result of many factors, including:

- Increased public awareness;
- Reduced and/or non-existent federal, state, and local social service resources; and
- Growth in population in Texas in general.

The challenge for DFPS is determining how to effectively address the volume of reports of abuse, neglect, and exploitation in its programs. DFPS will continue to work with the Texas Health and Human Services Commission (HHSC) to monitor demographic projections and develop plans to address the growing needs.

Strong and effective coordination among clients, communities, service providers, and state and local leaders is critical to the shared goal of providing services and solutions for the protection of vulnerable Texans. While these partnerships are essential in meeting demand for client services, they have not, to this point, always been sufficient to meet clients' service needs. For example, DFPS has had to address challenges finding adequate and appropriate placements for children in CPS care.

The root of this challenge is the fact that the number of foster children is growing faster than the capacity of homes and facilities that care for foster children. In only five years, the number of foster children grew approximately 43 percent, while the number of foster parents and other licensed placements grew 28 percent. This difference puts pressure on the entire system. In several ways, both short and long-term, inadequate capacity impacts children in care and their movement through the system to a permanent setting. Approximately one in six children must be placed out of their home region, and many more are placed within their home region but beyond their home county. Sometimes these placements are intentional, to place children near relatives or in a county near the child's home even though it is in another region. Other times, such a placement is not the preferred option, arranged only because either local placements are not available at all, or the placements available do not meet a child's needs. A common example is when children from rural areas must be placed across the state in large urban centers because of a lack of residential treatment options in their home region. These distance placements make it difficult for the children to have regular contact with their families and to maintain ties to their home communities.

Another common challenge is finding adequate placement options for sibling groups. Brothers and sisters may have to separate while in foster care because their needs differ such that they require different types of placements. Sometimes, there is not more than one available bed in the same foster home.

One of the more dramatic capacity challenges for foster youth includes a small but highly publicized number of children who have had to stay overnight in DFPS offices, or other locations supervised by DFPS staff, because no immediate and appropriate placement was available. This group is comprised mostly of older youth with challenging behaviors that many foster care providers are reluctant to accept.

DFPS is implementing a number of short-term and long-term solutions for increasing the number and variety of placement options. The plan associated with the efforts is detailed later in this document. There are significant opportunities for DFPS and its partners to explore new service delivery models, including the possibility of outsourcing some functions currently performed by the department.

Improved Contracting

As part of the Texas Health and Human Services (HHS) Enterprise contracting improvement initiative for the HHS Enterprise agencies, DFPS has assessed its current business practices associated with contracting to ensure that contracts are procured and managed in the most efficient way. To meet the service needs of clients, DFPS continues to:

- Standardize contracting processes across the state;
- Provide training and tools to help staff with contract procurement and management; and
- Stabilize and improve current contracting processes before significant new contracts are established.

As service delivery changes and becomes organized around contracting performance, the agency continually reassesses the organizational structure for opportunities for increased efficiency and effectiveness.

A critical DFPS contracting effort involves the ongoing conversion from effort-based contracting to performance-based contracting. Performance-based contracting has required change in DFPS definitions of success and/or compliance and in the measurement methodology for DFPS staff and contractors. Strategically, there are opportunities to leverage technology to increase both internal efficiency and contractor accountability. These efforts are discussed at length later in this chapter.

Infrastructure Demands on the Agency

DFPS has been at the forefront of innovation in its implementation of technology solutions to reduce administrative burdens and increase efficiency for its caseworkers. Employees in each of the three largest DFPS programs now have tablet PCs that allow them to spend more time in the field, enter and access information more quickly, and spend less time on administrative tasks. However, mobile computing requires a holistic approach to user support that is significantly more time-intensive and detailed than in a desktop environment. Caseworkers rely on timely technical support to manage caseloads and to complete crucial case documentation. Timely support is needed for the many components of the new hardware, the wireless services, and custom applications, as well as training and clarification of available features.

Additionally, DFPS has sometimes struggled in keeping up with the physical plant needs of an expanding workforce. New employees have required new offices and new training space. Providing adequate support services for the daily operations of the agency has been challenging, due to the approximately 25 percent increase in staff size due to the reform efforts of the last three years. DFPS continues to work with HHSC and the Texas Facilities Commission to acquire new leases for office space and ensure sufficient support for new and existing staff.

Funding

Managing a complex financing system is an important internal challenge for DFPS. The agency relies heavily on federal funding that continues to evolve. Massive changes in cost allocation methodologies and processes could result as DFPS' federal partners make changes to eligibility, system requirements, and allowable costs. When federal policies, programs, and funding mechanisms are altered, DFPS financial and other agency staff must prepare for the changes and any potential loss of funds in a number of ways. Preparation may involve:

- Adjusting the agency's method of finance where flexible for programs;
- Re-evaluating allowable financial sources for funding agency staff;
- Making modifications to the cost allocation plan;
- Evaluating DFPS policy changes which would preserve federal funds; and
- Seeking additional funds from the Legislature to mitigate the loss of federal funds.

DFPS will provide comprehensive, proactive financial planning to preserve federal funds where possible and to mitigate any loss of federal funds, including requesting additional legislative appropriations when needed.

Current Activities by Goal: Target Populations, Service Descriptions, and Trends and Initiatives

DFPS Goal 1: Protective Services

In collaboration with other public and private entities, DFPS protects children, elder adults, and persons with disabilities from abuse, neglect, and/or exploitation by providing an integrated service delivery system that results in quality outcomes, and reduces the incidence of abuse, neglect, and exploitation by maximizing resources for early intervention, prevention, and aftercare.

Adult Protective Services

Target Population

Elder adults and persons with disabilities who live in Texas are target populations for the APS division. There are more than 2.3 million Texans 65 years of age or older and more than 1.9 million adult Texans 65 years of age or younger and recognized as disabled. APS is responsible for serving each elder adult or adult with a disability who is alleged to be in a state of abuse, neglect, and/or exploitation in the individual's own home or in state operated and/or state-contracted MH and MR facilities.

After investigations by the In-Home program in fiscal year (FY) 2007, 37,322 individuals were confirmed as victims. Of those, 17,398 were adults with a disability, and 19,924 were elder adults. More than 60 percent of these individual victims were women. The most common type of maltreatment was physical neglect, which was found in 63.6 percent of the cases validated. Ethnic groups were represented as follows:

- 46.8 percent Anglo;
- 21.2 percent African American;
- 20.5 percent Hispanic;
- 0.2 percent Native American;
- 0.4 percent Asian; and
- 10.9 percent from all other population groups combined.

In the MH and MR facilities Investigation Program, 8,088 investigations led to 891 confirmed cases in FY 2007. Neglectful supervision was found in 31.5 percent of these confirmed investigations, with physical abuse as the second most common type, found in 26.5 percent of the confirmed cases. State Schools were the most common setting for these investigations, accounting for 42.9 percent of confirmed cases.

During the strategic planning period of 2009-13, the number of completed In-Home investigations is projected to increase steadily due to the growth in the number of individuals 65 years of age or older, particularly as “baby boomers” begin to enter into retirement age. Texas population growth will impact both In-Home and MH and MR Facility investigations.

Service Description

APS operates two programs: In-Home investigations, and MH and MR Investigations. The APS in-home program investigates reports of abuse, neglect, and/or exploitation of elder adults (defined as 65 years of age or older) and adults with disabilities who reside in community settings, as opposed to institutions. As appropriate, agency employees provide or arrange for protective services, including referrals to other programs, respite care, transportation, counseling, and emergency assistance with food, shelter, and medical care. The In-Home Program completed 64,459 in-home investigations in FY 2007, with 45,934 investigations resulting in confirmed allegations of abuse, neglect, and/or exploitation.

The MH and MR Investigations Program investigates reports of abuse, neglect, and/or exploitation of clients receiving services in state- operated MH and MR facilities (state hospitals, state schools, and state centers) and/or state-contracted settings (intermediate care facilities for persons with mental retardation, home and community-based services programs, and the Texas Home Living Waiver Program) that serve adults and children with mental illness or mental retardation. In FY 2007, there were 8,088 completed investigations in MH and MR settings, of which 2,139

were performed in state hospitals, 3,470 in state schools, 186 in state centers, 1,666 in home and community services, and 627 in community centers.

Child Protective Services

Target Population

According to the Texas State Data Center, 6.4 million children live in Texas. The CPS program focuses on Texas families in which children are suffering from abuse and/or neglect. To protect these children, CPS may provide services to the parents and other family members who may be responsible for the abuse or neglect. The following paragraphs describe both certain characteristics of the children served by CPS and also the placement types for these children.

Table 8.1 depicts the ethnic and gender representation of the more than 71,000 children in confirmed cases of abuse or neglect.

Table 8.1.
Characteristics of Confirmed Victims of Child Abuse, FY 2007

Sex	Anglo	African American	Hispanic	Native American	Asian	All Other Population Groups Combined
Female	12,204	7,316	16,150	51	118	1,183
Male	11,430	7,185	14,171	61	138	1,198

Table 8.1: Texas Department of Family and Protective Services, Databook, FY 2007.

In 29 percent of these confirmed cases, children may require substitute care outside of their homes of origin. At the end of 2007, DFPS had legal conservatorship for 27,458 children in substitute care. Table 8.2 details the types of placements in which these children were residing.

Table 8.2.
Children in Substitute Care Placements, by Living Arrangement at the End of FY 2007

Type of Living Arrangement	Number of Children	Percentage of Total
DFPS Foster Homes	2,359	8.6%
Contracted Foster Homes	11,732	42.7%
Basic Child care	812	3.0%
Residential Treatment Centers	1,392	5.1%
Emergency Shelters	625	2.3%
Other Foster Care	434	1.6%
Kinship Care	8,533	31.1%
DFPS Adoptive Homes	286	1.0%
Private Adoptive Homes	477	1.7%
Independent Living	203	0.7%
Other Substitute Care	605	2.2%
Total	27,458	100.0%

Table 8.2: Texas Department of Family and Protective Services Data Warehouse, December 2007.

Of the children residing in foster care at the end of FY 2007, 53.1 percent were boys and 46.9 percent were girls. Age groups were represented as follows:

- 21.3 percent were two years of age or younger;
- 15.6 percent were from 3 to 5 years of age;
- 17.7 percent were from 6 to 9 years of age;
- 17.9 percent were from 10 to 13 years of age;
- 25.3 percent were from 14 to 17 years of age; and
- 2.3 percent were from 18 to 20 years of age.

Ethnic groups of the children in foster care were represented as follows:

- 31.2 percent Anglo;
- 28.9 percent African American;
- 37.6 percent Hispanic;

- 0.2 percent Native American;
- 0.3 percent Asian; and
- 1.7 percent all other population groups combined.

Of some note is the fact that the population of children in DFPS conservatorship had steadily been increasing until March 2007, when it began a slow decline that continued through the next year. This occurred despite the fact that investigations are at an all-time high. While there are many factors to which this decline may be attributed, many of the family-centered practices implemented during agency reform contributed to diversion from foster care and to more prompt achievement of child permanency goals.

Service Description

The CPS program focuses on three main outcomes: ensuring safety for children, establishing permanency for children, and ensuring family and child well-being. To achieve these outcomes, the division administers seven main stages of service:

- **Intake—**initiated when a report of suspected abuse or neglect is received;
- **Investigation—**conducted to determine whether a child has been abused and/or neglected, or to determine whether there is a risk of abuse or neglect;
- **FBSS—**provided to the family in the family's home, when a child's safety can be reasonably assured there;
- **Substitute Care Services—**provided when the child is not safe in the home; these out-of-home care services include foster care and adoption services;
- **Family Reunification Services—**provided when the court determines that a child should return home after residing in foster care; and
- **Preparation for Adult Living—**provided to youth 16 years of age or older to aid with the transition from foster care into adulthood.

In FY 2007, the CPS program conducted 163,471 investigations of abuse and/or neglect and confirmed abuse and/or neglect in 42,445 of those cases, or 26 percent. Risk factors for further maltreatment were identified in 78 percent of the investigations. The most commonly found types of abuse were physical abuse, physical neglect, and sexual abuse.

These 42,445 confirmed cases of abuse or neglect involved 71,344 children. Of the investigated cases, 25,453 involved one or more of the following services:

- **FBSS—**16,930 families (66.5 percent);
- **In-home purchased services—**1,105 families (4.3 percent); and
- **Substitute care services—**1,105 families (4.3 percent).

Child Care Licensing

Target Population

There are two main target populations for the CCL division:

- Children attending day care for less than 24 hours per day; and
- Children residing in residential child care facilities.

In FY 2007, capacity of legal child care operations in Texas was 1,003,647 children. The capacity of residential care providers was 45,758 children.

These children's caregivers—parents, guardians, and/or service providers—are also target populations.

Service Description

The CCL division safeguards the basic health, safety, and well-being of Texas children by developing and enforcing minimum standards for child care facilities and child-placing agencies. The division investigates complaints and serious incidents involving daycare and residential care facilities, and, if necessary, the division takes corrective or adverse action. Licensing employees also provide training and professional development for staff of licensed and registered facilities. Training topics offered include meeting child care minimum standards, record keeping, child health and safety, nutrition, age-appropriate activities, child guidance, and discipline.

The program regulates licensed and registered child day care homes, licensed child day care centers, listed family homes, child-placing agencies, and residential child care facilities. Monitoring these facilities involves investigations of standards violations and/or abuse and neglect of children within those facilities and homes. The following paragraphs focus on the demand for services within the different facility types.

<u>Day Care Licensing</u>

In FY 2007, more than four million children 13 years of age or younger lived in Texas. Many of these children are in the care of a day care provider on a regular basis for a substantial part of the day. In FY 2007, CCL was responsible for monitoring 9,319 licensed child day care centers, 1,536 licensed child care homes, 7,214 registered family homes, and 3,900 listed homes with a combined capacity to serve more than one million Texas children. Table 8.3 lists the total number of licensing inspections performed in day care facilities and registered homes.

Table 8.3.
Number of Inspection Visits in
Regulated Child Care Facilities, FY 2007

Day Care Facilities	Total Number of Facilities	Number of Inspection Visits
Licensed Child Care Centers	9,319	30,163
Licensed Child Care Homes	1,536	3,613
Registered Family Homes	7,214	8,246
Listed Homes	3,900	595
Total	21,969	42,617

Table 8.3: Texas Department of Family and Protective Services, Databook, FY 2007.

There appears to be some movement of capacity from smaller, family-based homes into center license types, as this is where the greatest growth has been. The number of inspections in regulated care rose by five percent in FY 2007 over the previous year.

Residential Licensing (24-Hour Care)

The CCL program is also responsible for licensing and monitoring 24-hour child care facilities, including residential child care, CPS foster homes, and child placing agencies and the foster homes they license. In FY 2007, CCL issued permits for 38 new residential child care facilities and performed inspection visits in 8,839 residential child care facilities. This represents a 64 percent increase in inspections over FY 2006, brought about by new program expectations.

**Table 8.4.
Number of Inspection Visits in
Residential Child Care Facilities in FY 2007**

Residential Child Care Facilities	Total Number of Facilities	Number of Inspection Visits
Facilities	242	2,203
Independent Foster Homes	4	67
Child-Placing Agencies	332	3,795
Agency Foster and Foster Group Homes	6,789	2,214
CPS Foster and Foster Group Homes	2,761	650

Table 8.4: Texas Department of Family and Protective Services, Databook, FY 2007.

Prevention and Early Intervention

Target Population

The PEI target populations mirror the CPS program populations; however, prevention services contracts target specific regions of the state and, in some cases, specified client groups. Prevention services contracts include the following programs.

- **Community Youth Development (CYD)—**CYD targets communities with a high incidence of juvenile crime and provides youth development activities and family support programs aimed at the prevention of juvenile crime. The FY 2007 average monthly number of CYD youth served was 3,353.
- **Services to At-Risk Youth (STAR)—**STAR targets youth who are runaways living in family conflict, are truant, or are at risk of running away. The program also serves both children younger than 10 years of age who have allegedly committed delinquent offenses and youth from 10 to 16 years of age who have committed misdemeanor or state jail felony offenses. This program also provides statewide universal child abuse prevention services. In FY 2007, 32,085 STAR youth were served.
- **Texas Families: Together and Safe—**Texas Families provides family support grants. Programs operated under these grants are designed to alleviate stress, promote parental competencies, reduce barriers to accessing services, and increase the family's ability to nurture their children. In FY 2007, 2,741 families were served.

- **Community-Based Child Abuse Prevention—**The program seeks to increase community awareness of existing prevention services, strengthen community and parental involvement in child abuse prevention efforts, and encourage families to engage in services that are already available. In addition, a new model has been introduced that supports the development of community partnerships comprised of parents, community members, community and faith-based organizations, and government agencies working to improve outcomes for children, youth, and families.
- **At-Risk Prevention Services Program—**This relatively new program targets services to at-risk families and youth who manifest specific risk factors or behaviors, who are thereby considered likely candidates for the condition that is to be prevented, specifically child maltreatment or juvenile delinquency. Services are designed to build resiliency in families and youth, proactively to increase protective factors, and to increase confidence and competence in their abilities to solve problems, avert crises, and advocate on their own behalf. This program provides evidence-based services addressing either child abuse and neglect or juvenile delinquency.
- **Texas Youth and Runaway Hotlines—**These hotlines serve exclusively Texas youth and families, by providing both 24-hour crisis intervention and telephone counseling and information and referral services. The hotlines handled 35,548 calls in FY 2007.

Service Description

The PEI division manages the statewide prevention services contracts described above. The division focuses on contracting for quality services and is charged with identifying and measuring meaningful outcomes for contracted services.

DFPS Goal 1 Trends and Initiatives

Two DFPS strategic initiatives that will impact the 2009-13 planning period are focused on some of the most challenging concerns the agency has faced: the ability to build and maintain a quality workforce and the need to develop provider capacity to meet the needs of youth and children in the care of DFPS. The current strategic approach is strengthened from prior efforts to address these concerns, in that they are now being approached as executive-level chartered projects with agency-wide scope. Prior efforts, while often productive, sometimes operated within one or another of the agency's many divisions, with limited cross-agency coordination.

In the last iteration of the Strategic Plan, DFPS's initiatives were heavily focused on the goals of reforming the agency. With this initial work largely completed, another current initiative seeks to continue and expand upon the gains made during the reform period of the last three years.

Contracted Foster Care Services Capacity

DFPS is engaged across the agency and with other health and human services agencies to employ strategies that will build foster care capacity. The various strategies can be channeled into one goal: strengthening the ability of the Texas child welfare system to meet the needs of children in foster care.

To achieve this goal, DFPS has established three main objectives:

- Planning and implementing strategies for community-based capacity development;
- Working towards internal coordination, program efficiencies, and communication practices that result in effective business relationships with providers and stakeholders, and
- Promoting best practices and innovations in purchased service delivery.

This initiative encompasses a wide range of activities and will be managed at the executive level.

A Statewide Placement Quality and Capacity Needs Analysis will review substitute care and adoptive placement services in local communities, compare placement and other resources with the needs of foster children and their families, and identify solutions to meet those needs. DFPS is currently procuring external expert assistance services to conduct the statewide needs analysis. Based on the results of the analysis, DFPS will develop a Residential Capacity Strategic Plan to address foster care capacity. This agency plan will chart a course including both methods for regionally targeted placement and service development and improvements to internal agency operations that impact placement capacity. DFPS is currently collaborating with a university to conduct the statewide needs analysis.

Within the CPS program, efforts will be made to analyze the impacts of the successful centralized placement process and to identify potential enhancements. Processes will be mapped in an effort at statewide efficiency and consistency. Similar efforts will involve expediting verification of DFPS foster homes, so the time between when a family submits an application and when they are ready to foster a child is less than 120 days. This work will occur in two phases. The first phase entails business process mapping, to identify ways to streamline and expedite the process, and this analysis will yield opportunities for role clarification, training on quality expectations, and increased accountability. The second phase of the initiative will focus on implementing the changes identified.

Another section of the capacity-building initiative will develop recommendations for a pilot program for outsourcing of case management services with the highest degree of possible success. DFPS will not be procuring services; thus, the agency will be able to more actively solicit provider opinion than in prior efforts related to outsourcing. DFPS will conduct outreach to providers and other stakeholders around the state to gather perspectives on how a successful contracted case management model would be best structured and managed. Additionally, DFPS will

consider best practices from around the country in developing the proposed alternative model. This research of national best practices, combined with comprehensive input from existing and potential Texas providers of child and family services, will result in a more thoughtful, systemic, and achievable approach to outsourcing of case management services, and it will be the basis for future legislative initiatives.

Within the agency, DFPS will analyze and seek areas for further coordination among internal divisions and contractors that regularly interact with residential care providers. This includes PCS, CCL, CPS, and Youth For Tomorrow (DFPS contract for service level determination). This work will explore the following options:

- Reducing duplication of efforts and documentation,
- Improving cross-division communication,
- Creating a consistent communication strategy with providers,
- Identifying provider needs for support and technical assistance related to effective residential child care management and competencies of the child care workforce, and
- Establishing appropriate avenues of delivering support and technical assistance through DFPS resources or partnerships with external entities.

It is anticipated that the DFPS capacity initiative and the capacity strategic plan will lead to innovative services or ways of purchasing services. Possible areas could include:

- Incentives outcomes,
- Improvements to performance metrics,
- Preferential placements with successful providers,
- Changes to rate structures or the service level system,
- Increased case management functions in contracted providers,
- New provider development, and
- New models for providing continuity of care and wraparound services.

Recommendations will be compiled and considered for future implementation by the project team, including changes to DFPS business practices and priorities.

Workforce Support and Retention Initiative

As the development of high-quality workforce remains one of the largest challenges to the delivery of quality services to clients, DFPS will be developing a comprehensive workforce effort, the Workforce Support and Retention Initiative (WSRI). The goal is to employ highly motivated, diverse, ethical, well trained, and professional staff who are committed to the agency's mission and well prepared to produce successful outcomes through proactive strategies, policies, procedures, and practices. The agency's effectiveness will be measured by whether there is a

reduction in annual employee turnover rates at the agency, specifically caseworker turnover rates. The initiative is organized into several main areas of work.

The Improving Hiring Practices component will identify and/or develop policies, procedures, and best practices to help the agency locate, recruit, and hire applicants with an aptitude for direct delivery work and the capability to provide the highest level of service to DFPS clients. The workgroup will collect, evaluate, and report on position-related data from different programs, to identify trends, isolate areas of concern, and recommend responses based on other successful strategies.

The office environment component will explore ways to improve the work environment for staff by addressing issues related to office space, worker safety, automation needs and innovations, and flexible work schedules. Because the office environment is a significant factor in worker morale and retention, providing appropriate space and tools to staff is imperative. The workgroup will need active input from state office support staff, program leadership, and regional field staff. The group will require ongoing consultation with HHS Enterprise groups, including Human Resources, Facilities and Leasing, Regional Administrative Services, and Risk Management.

The Promoting Employee Communication and Input (PECI) area of the WSRI will serve as a central gathering point for employee input, with a primary focus on workforce support and retention. The PECI workgroup will ensure all the relevant divisions are consulted when issues cross more than one division of the agency. In addition, the PECI will serve as a resource to the other WSRI workgroups on communication issues/projects related to this initiative.

A regional retention pilot has been established to develop retention strategies at the local level to mitigate turnover, and reduce case/workloads, to improve outcomes for families and children. This retention strategy is based on the assumption that each region carries different economic, cultural, and geographical challenges; thus local leadership should guide the solutions that impact their regions.

Finally, the WSRI will work to develop and support supervisors. Quality supervision may be the single most important factor in DFPS's ability to retain staff. Research shows that employees who remain in human services are more likely to report that their supervisors are willing to listen to work-related problems and to help them get their jobs done, while employees who leave or are planning to leave are less likely to report this. Employees staying in human services rate their supervisors as more competent, willing to show appreciation, approachable, and concerned for their well being than do those who leave.

Building on the Progress of Agency Reform

DFPS made significant progress in all of its programs and operations as result of the implementation of S.B. 6. As the 80th Legislative Session approached, DFPS sought and found legislative support to build on the gains of agency reform. Legislative

leadership encapsulated the goals of the continued reform efforts in S.B. 758, 80th Legislature, Regular Session, 2007, by Senator Jane Nelson and Representative Patrick Rose.

The legislation provided the guidance, support, and resources for the agency to continue improvement for the next few years to come. The agency is actively implementing many of the provisions. Broadly, S.B. 758 sought to build on the prior reform efforts in three key areas:

- Keeping families together while ensuring child safety in the home;
- Reducing the length of time children remain in state care; and
- Improving the quality and accountability of foster care.

These efforts have become informally known as "Reform Two." Agency strategic efforts to advance the goals of reform are varied and far-reaching.

The successful Family Group Decision-Making (FGDM) is a model where DFPS employees facilitate interactions with family and other persons who support the child, to engage families in problem-solving. DFPS has been using FGDM in the CPS substitute care stage, after a child is removed from the home. DFPS is expanding FGDM to make it available to families during an investigation, to help prevent the removal of children. It is designed as a rapid response to child safety and placement concerns.

In cases where child safety can be assured after a validated case of abuse or neglect, DFPS offers services to mitigate the risk of maltreatment while keeping a family intact. This stage of service is FBSS. DFPS policy requires standards for monthly contacts for three levels of intensity for FBSS cases: regular, moderate, and intense. National data shows that regular, meaningful contact in FBSS cases is directly related to positive outcomes for children in these cases.

With legislative support, DFPS is building the ranks of FBSS staff, to lower overall caseloads. Lower caseloads will improve safety for children, improve child and family well-being, and divert children from entering the foster care system. DFPS has further increased the chances of successful outcomes in FBSS though the "Strengthening Families through Enhanced In-Home Support" pilot. This project expands on the current FBSS model, using Temporary Assistance for Needy Families funding to help offset certain poverty-related factors. Providing this assistance will help families working with CPS to avoid removal of children or to speed the process of reunification of children with their families.

To reduce the length of time children remain in the foster care system, DFPS has added resources to achieve the following goals:

- Offering services that are realistic, accessible, and available to children and families;
- Lowering substitute care caseloads to meet federal requirements; and
- Achieving permanency in a timely manner.

This part of the initiative includes expansion of the use of FGDM, reduced caseloads for caseworkers providing ongoing substitute care services, additional purchased client services designed to reunite families more quickly while ensuring child safety, and enhanced support of kinship placements.

Kinship care, as a diversion from foster care, will be strengthened by additional workers to provide support and education to relatives with whom a child is placed, and purchasing additional support services will also help these families. As another part of the initiative to continue agency reform, DFPS will focus on two areas related to legal services that required additional resources: redaction and court personnel. This will speed adoption and permanency goals.

Finally, as part of the ongoing strategic initiative, DFPS has sought resources to improve the quality and accountability in regulatory services delivered by DFPS and services delivered by contracted providers. To do this, child care licensing monitoring and investigations were split into specialized units, and new expectations of agency responses were developed for investigations involving young children. Background checks will be streamlined, and technological solutions are being planned to increase the efficiency of regulators.

The department is also developing a statewide pilot program for a time-limited, post-hospitalization “step-down” rate to support the successful transition of children who have experienced or are likely to experience multiple inpatient admissions in a psychiatric hospital. In the PCS division, there is a planned automation solution to increase the efficiency of contract monitoring by the elimination of paper processes. This will also allow collection of contractor data that will show high and low performance in achieving contract terms and positive client outcomes.

DFPS Internal Assessment

This section represents an evaluation of the key internal factors that influence DFPS. Below is a discussion of the agency’s internal processes and operations, and its perceived strengths and challenges.

DFPS Internal Processes

Over the last three years, significant changes and improvements have been made to DFPS internal processes. Structural changes were designed to increase accountability, eliminate delays, and achieve better quality investigations and outcomes for clients.

The creation of subject matter expert positions in regional DFPS programs allowed specialized expertise in working with staff and the community to improve services.

Case screeners assist CPS investigative caseworkers by screening and prioritizing cases, and child safety specialists provide expertise for the risk assessment process. CPS organized into functional units for all stages of service, which reduces supervisor span of control and increases caseworker support. To improve administration, reform called for the creation of an Office of Investigations to oversee and direct CPS investigative functions.

DFPS continues to implement an agency-wide accountability and performance management system that when fully deployed will impact all programs and divisions within the agency. The system includes client-centered outcome measures, job performance standards, case reviews, and improved performance reports for management oversight. Case quality and timeliness goals are being consistently integrated into the performance evaluations of all staff. Standardized reporting of internal program performance metrics have been developed and are a routine part of executive management's oversight.

While programmatic changes were the most visible and meaningful changes for DFPS clients, areas of internal operations had to incorporate significant changes of their own to support the reform efforts. Processes had to be developed to hire thousands of new staff and to support new technology. Project management processes had to be developed to ensure reforms were proceeding as planned. New financial models had to be developed to account for staff in functional units. Training had to be developed on new policies and procedures. No part of the agency was untouched.

DFPS Internal Operations

DFPS internal operations are currently performed by the offices and units described below.

Chief Operating Officer

The Chief Operating Officer (COO) is responsible for coordinating the administrative functions that support program operations. The COO reports directly to the DFPS Commissioner. The COO includes the administrative functions listed below.

- **Information Resource Management—**This section supports the agency's information technology needs across all operations, by maintaining computer hardware, providing network connectivity, data storage, problem resolution, and similar activities.
- **Legal Services—**This section provides the legal counsel, training, and services needed to support the agency's mission and to ensure that the agency complies with all applicable state and federal laws.
- **Program Support—**This section provides the day-to-day guidance and coordination for the agency's program support functions, including client service information system end-user support and testing, custom client

service application security and data retrieval, and facility management oversight and coordination.

- **Management Support—**This section provides the day-to-day direction, guidance, and coordination for the agency's management service functions. The section works with the DFPS management team to identify and resolve cross-agency operational issues, and the section coordinates internal communication in support of the agency's mission and operational goals. These include such areas as performance management oversight, management reporting and statistics, records management, continuity of operations, and human resources functions not outsourced or centralized to HHSC.
- **Contract Oversight & Support—**This section develops and maintains agency-wide contracting policies and procedures, provides support and technical assistance to staff with contracting responsibilities, and has oversight responsibilities related to contract policy adherence and contract related data.
- **Statewide Intake—**This program operates 24 hours a day, seven days a week, year-round, and it is the centralized contact center for reporting abuse, neglect, and exploitation of children, older people, and adults with disabilities. In addition to taking phone calls, Statewide Intake receives faxes, letters, and Internet reports that are reviewed, assessed, and entered into the DFPS automation system by an intake worker. In FY 2007, the program handled 647,909 calls, faxes, letters, and Internet reports

Chief Financial Officer

The Chief Financial Officer (CFO) is responsible for managing the financial activities of DFPS. The CFO reports directly to the DFPS Commissioner and is overseen by the Deputy Executive Commissioner for Financial Services at HHSC.

The financial functions under the CFO include the sections described below.

- **Accounting—**This section is responsible for managing the agency's financial transactions and ensuring the integrity of the accounting records. Responsibilities include processing travel claims and providing travel support, processing payments to vendors, requisition processing, cash management, cost allocation, and financial system support.
- **Budget—**This section is responsible for developing and monitoring the agency's annual operating budget, maintaining position control, working with program areas to determine the allocation of resources to the regions, developing the biennial legislative appropriations request, preparing fiscal impact analyses on proposed legislation and agency rule changes, and providing fiscal analysis and reporting. This section is also responsible for regional budget activity.

- **Federal Funds—**This section provides analytical support consultation and technical assistance to the program areas to maintain existing federal funding initiatives and to design new initiatives. This section is responsible for:
  - Reviewing and analyzing costs, programs, and federal claims, to ensure the agency is claiming all eligible costs,
  - Participating in the design/review of cost allocation methodologies, and
  - Tracking and analyzing federal legislation related to funding.

Office of Deputy Commissioner

The Office of the Deputy Commissioner provides vision, leadership, and strategic direction for program service delivery. The Deputy Commissioner also serves as a catalyst to increase consistency and standardization within DFPS and among health and human services agencies. This office provides leadership and oversight to: the Center for Policy and Innovation (CPI), the Center for Consumer and External Affairs (CCEA), the Center for Program Coordination (CPC), and a variety of cross-divisional agency projects.

Center for Policy and Innovation

CPI develops training and coordinates policy to equip DFPS employees with the skills and knowledge necessary to protect the unprotected. It is organized into two complementary divisions. The Policy and Innovation Division oversees and directs the development of DFPS policies, rules, and plans, and it provides related technical assistance. The Professional Development Division develops, conducts, and coordinates training for DFPS program staff to ensure the safety of clients and staff. Since DFPS's Reform effort, PDD has focused primarily on basic skills development courses for workers in APS, CPS, CCL, and Statewide Intake (SWI). PDD also provides basic supervisory and leadership training for DFPS staff and works with the Protective Services Training Institute of Texas (PSTI) to provide professional development to DFPS staff beyond the basic skills training and certification.

Center for Consumer and External Affairs

CCEA facilitates cohesive, professional communications and relationships between DFPS and the public, the media, and the Legislature. CCEA further coordinates consumer and external affairs activities with related HHSC offices and serves as the point of contact for the DFPS Council, the Governor's Office, the media, and community stakeholders. CCEA also provides centralized support for the Commissioner. The CCEA mission is to serve as the agency's external liaison, and to provide DFPS staff with professional consumer and external relations support and guidance with both agency-wide and external perspectives.

There are three main divisions within the CCEA. External Relations serves as the liaison to the Legislature, elected officials, and other state agencies, to build relationships and facilitate communication. External Relations also establishes

agency policies and procedures for statewide community engagement and volunteer resource development, and the division provides centralized support, planning, and communications to the DFPS Council. Communications serves as the primary point of contact for the media and public inquires and is the liaison to HHSC and other Enterprise Communication Offices. Consumer Affairs receives, catalogues, and responds to complaints and legislative inquiries and uses this information to inform state and regional DFPS administrators of identified areas of possible improvements to program policies and procedures.

Center for Program Coordination

CPC is responsible for much of the agency's project management of large-scale agency initiatives. CPC coordinates the Executive Steering Committee, which oversees the DFPS project management. CPC project management ranges from consultative work in developing charters and work plans to full time project management and oversight. CPC staff work in a variety of business process improvement projects, especially those involving multiple divisions or other HHS agencies. CPC performs research and data-gathering, including development of survey instruments for a wide variety of purposes, and analysis of complex challenges to agency work. Ad hoc projects account for a significant amount of the CPC workload and have included such efforts as regional management reviews, coordination of the Sunset Review and the HHS strategic planning processes, and development of external reports.

DFPS Internal Strengths and Challenges

Dedicated Staff

Employees at all levels of the organization remain committed to the mission of DFPS, that of protecting children, older people, and adults who have disabilities. Employees have continued to provide necessary services even when challenged by significant workloads and changes to policies and programs. As cited previously, building a well equipped workforce remains a challenge that DFPS will strategically address with activities to increase productivity, minimize employee turnover, and help employees maintain a positive attitude.

Leadership Development and Succesion Planning

DFPS recognizes that leadership development will improve its capacity to implement ongoing improvements. As part of the WSRI initiative, the agency will address the needs of supervisory level staff as well as plan for the challenges created through retirement of senior leadership.

Community and Stakeholder Involvement

DFPS has made a commitment to involve stakeholders in the implementation of new and existing policies and procedures. Efforts have been made to identify essential stakeholders and their specific interests. Agency-wide strategic plans have been developed to coordinate and support activities involving collaborations, partnerships, and community involvement in client outcomes. The plans provide a consistent approach while allowing flexibility by program and at local levels, to accommodate different goals, priorities, and limitations. DFPS continues to enlist the support of internal and external stakeholders for changing policies and procedures and to ensure they understand the impact of DFPS program and process improvements.

Technical Innovation

DFPS has consistently sought solutions to increase staff efficiency and responsiveness, and the agency continues to develop its mobile workforce. Several projects have received external recognition for their contribution to improved client services. As various projects have been deployed, the agency has increased its emphasis on developing technology that complements and enhances the natural workflow of its field staff. Challenges include creating the infrastructure necessary to support these enhancements.

Communications

With 10,000 staff in more than 200 locations, DFPS is a large, dynamic, and complex organization, and communication is essential for successful implementation of the agency mission. DFPS has developed a comprehensive communications strategy that fosters consistent internal and external messaging, cultural shift within the agency, and better understanding and acceptance of the agency's mission by employees, the public, providers, and other stakeholders.

Internal Processes

Through the course of agency reform, DFPS had to create new ways of addressing a variety of activities. Some of these activities include:

- Recruiting, screening and hiring of new staff;
- Position control;
- Performance management;
- Electronic communication;
- Workflow management;
- Development and delivery of training;
- Technological tools;
- External relations;
- Facilities procurement;

- Project management; and
- Contracting practices.

As the agency moves into an ongoing quality improvement mode, these internal processes will continue to support accountability and efficiency. A challenge remains in that the resources afforded to these support areas have not always kept pace with agency growth.

In summary, the work of reform in DFPS is not viewed as the completion of an externally driven plan but as an essential foundation for the future of the agency. As DFPS plots its strategic direction for the 2009-13 planning period, it will build on the achievements of its staff in embracing the comprehensive, systemic changes brought about by reform. Further, it will use the lessons of the last few years to address some of its most daunting challenges to delivering high quality and accountable services to vulnerable Texans.

Chapter IX

Department of State Health Services External/Internal Assessment

The Department of State Health Services (DSHS) is a large state agency responsible for oversight and implementation of public health and behavioral health services in Texas. With an annual budget of $2.7 billion and a workforce of 12,000, DSHS is the fourth largest of Texas' 178 state agencies. The DSHS vision is "A Healthy Texas," and the agency mission is "*To improve health and well-being in Texas*."

The material in this chapter is arranged as follows:

- Challenges and Opportunities;
- Current Activities by Goal:
  - Target Populations;
  - Service Descriptions; and
  - Trends and Initiatives; and
- Internal Assessment.

Challenges and Opportunities

Challenges

Texas faces many challenges relating to the health of Texans. DSHS is directly responsible for addressing a number of these issues and serves in a leadership or supportive role on many others.

- Measurement of health status and recognition of health disparities are important to addressing many of the state's health challenges.
- Over the past century, basic public health activities such as immunizations, sanitation improvements, and food quality control, have helped increase life

expectancy by 30 years. These essential services must be supported and maintained to sustain health successes of the past.

- Many of the current health challenges for the state relate to lifestyle choices, with some of these choices leading to chronic diseases.
- Various infectious diseases remain a threat to Texans.
- Mental illness and substance abuse have a significant impact on Texas communities and families and require efforts to prevent or mitigate their statewide effects.
- Unintentional injuries have a significant impact on the health care system.
- Public health emergency preparedness is integral to the effective response to public health threats, such as pandemic influenza, hurricanes, and bioterrorism. DSHS is a leader in these efforts, working within the state's emergency operations system.
- DSHS must maintain its capacity to support its health service delivery system.

Health Status and Health Disparities

Realizing the agency vision of *A Healthy Texas* requires acknowledgement of the health indicators that lead to wellness or to sickness, death, or disability. The leading health indicators and whether or not individuals become sick or die have to do with a mix of lifestyle behaviors, including tobacco use, physical activity, healthy eating, substance use, and responsible sexual behavior. Other factors include the mental health status of individuals, injury and violence, environmental quality, immunizations, and access to health care (*Healthy People 2010*).

These indicators are important to: (1) analyze as a means to identify future trends and their consequential impact on the overall health status of Texans, and (2) utilize as the foundation upon which to enhance the Texas public health and behavioral health service delivery system.

Insight into health status and how to improve it can be gained through identifying health disparities, formally defined by the National Institutes of Health as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups." Examples of these specific population groups include race, culture, gender, age, economic status, and geographic distribution. Other characteristics include social class, education, disability, and sexual orientation.

The racial and ethnic diversity of the Texas population is a particularly important factor in describing the state's health now and in the future. In 2006, more than 51 percent of Texas' 23.5 million residents were Hispanic, African American, or members of another minority race or culture. Differences in health status among ethnic and racial groups, if left unattended, may potentially show a magnified impact as the ethnic and racial diversity of the population as a whole continues to increase.

Traditional Public Health Activities

The contribution of public health to our society is measured in the dramatic improvements in well-being and life expectancy during the 20th century. During the last century, the life expectancy of Americans increased by 30 years, from 47 to 77, and it is estimated that 25 of those years are attributable to public health, rather than improvements in drugs, treatment, and medical care. In 1900, the leading causes of death were communicable diseases—pneumonia, tuberculosis (TB), and diarrhea/enteritis. Pneumonia/influenza is the only one of the three remaining on the leading causes list, and it has dropped to being the eighth leading cause. Immunizations, clean water, clean air, sanitation improvements, food quality controls, and recognition of tobacco use as a health hazard has dramatically improved the quality of life for most Americans.

Tobacco Use

Tobacco use is the single largest cause of preventable, premature death and disease in Texas. Tobacco use is a primary contributor to lung disease, heart disease, and diseases of the mouth, breast, pharynx, esophagus, pancreas, kidney, bladder, and uterine cervix.

Almost 60,000 youth in Texas become daily smokers each year, and 20,000 of them will ultimately die from smoking. More than one of every five Texas adults currently smokes tobacco. Approximately 24,000 adults die of a smoking-attributable illness annually in Texas. This number is greater than the combined deaths annually from Acquired Immunodeficiency Syndrome (AIDS), heroin, cocaine, alcohol, car accidents, fire, and murder. For every one person who dies from tobacco-related causes, there are 20 more people who are suffering with at least one serious illness from smoking.

Obesity

The increasing prevalence of overweight and obese adults and youth is a serious concern for Texas. More than one in four adult Texans are obese, and more than six in ten are at an unhealthy weight (overweight or obese). In Texas in 2005, 13.9 percent of high school students were overweight, and 15 percent were at-risk for being overweight. Being overweight increases a person's risk of serious medical conditions that impact quality of life and have substantial economic consequences for the health care system.

Chronic Diseases

Chronic conditions are major causes of illness, disability, and death in Texas. Chronic diseases are generally characterized by multiple risk factors, a long latency period, a prolonged course of illness, non-contagious origin, functional impairment or disability, and low curability. These diseases claim more than 101,000 Texans annually and are responsible for seven of every ten deaths.

In 2004, the ten leading causes of death resulted in a total of 152,374 deaths.

Table 9.1
Leading Causes of Texas Deaths, 2004

Ranking	Disease	Number	Percentage
1	Heart Diseases	40,094	26.3%
2	Cancer	33,836	22.2%
3	Stroke-Related	9,831	6.5%
4	Accidents	8,270	5.4%
5	Lung Diseases	7,387	4.8%
6	Diabetes-Related	5,426	3.6%
7	Alzheimer's Disease	4,331	2.8%
8	Influenza and Pneumonia	3,198	2.1%
9	Kidney Disease	2,557	1.7%
10	Blood Infections	2,420	1.6%
All Other Causes		35,027	23.0%

Table 9.1: Department of State Health Services.

Cardiovascular Disease / Coronary Heart Disease / Stroke

Cardiovascular disease (CVD) refers to a group of disorders that affect the heart and blood vessels. Common forms of CVD include heart disease, stroke, and congestive heart failure. Risk factors associated with CVD include hypertension, tobacco use, high cholesterol levels, low physical activity, poor nutrition, and second hand tobacco smoke.

In 2004, CVD was the single highest killer of Texans. Also, in 2004, the crude death rate for heart disease was 178.3 per 100,000, and for stroke it was 43.7 per 100,000. By race and ethnicity, African Americans had the highest rates of mortality from CVD in 2004, compared with Anglos and Hispanics.

Cancer

Cancer represents more than 100 distinct diseases that are all characterized by the uncontrolled growth and spread of abnormal cells in the body. In Texas, as in the nation, the increasing population of older adults means that more and more people will be affected by cancer. Still, cancer risk, even in the elderly, can be modified. Significant contributors to the cancer rate include tobacco use, poor nutrition, physical inactivity, obesity, and other lifestyle factors. The significant growth of cancer prevention and control programs across Texas has led to the recognition that

improved coordination of cancer control activities is essential to maximizing resources and achieving desired cancer prevention and control outcomes.

By race and ethnicity, African Americans living in Texas had the highest rate of cancer in 2004. The age-adjusted rate per 100,000 was 433.6 overall, 488.1 for African Americans, 474.8 for non-Hispanic Anglos, 326.6 for Hispanics, and 273.0 for all other groups combined. It is estimated that in 2008 more than 97,000 Texans will be newly diagnosed with cancer and 38,000 will die from cancer.

Diabetes

Diabetes can lead to disabling health conditions, including heart disease, stroke, kidney failure, leg and foot amputations, and blindness. Estimates indicate that the total number of diabetes cases in Texas will increase by 77 percent in the next 30 years, from 1.3 million in 2005 to almost 2.3 million in 2040. Hispanics are projected to comprise the majority of diabetes cases.

Diabetes was the sixth leading cause of death in Texas from 2002 through 2004. In 2004, there were 5,426 deaths directly attributed to diabetes. The 2004 mortality rates (per 100,000) for African Americans (non-Hispanic) and Hispanics were more than double that of Anglos (non-Hispanic).

Infectious Diseases

Bacteria, viruses, or other microorganisms cause infectious diseases. Many infections plaguing Texans have common modes of transmission that relate to personal behaviors.

Human Immunodeficiency Virus Infection / Acquired Immunodeficiency Syndrome

Human Immunodeficiency Virus (HIV) is spread by sexual contact with an infected person, by sharing needles, by transfusion with infected blood or blood products, or by mother-to-infant transmission. In 2006, there were 60,571 persons known to be living with HIV/AIDS in Texas, a 33 percent increase over the number in 2002 (45,550). Over the past five years, the annual number of new diagnoses decreased slightly, from 5,364 in 2002 to 4,621 in 2006. From 2002 to 2006, more than one quarter of all HIV-diagnosed individuals received an AIDS diagnosis within one month of their HIV diagnosis, indicating that a substantial proportion of these individuals were not diagnosed until late in the progression of this disease.

In Texas, the rate of persons living with HIV/AIDS among African-Americans (868.3 per 100,000) was nearly five times higher than those for Anglos (196.7 per 100,000) and Hispanics (170.2 per 100,000). Also, many subpopulations in the largest metropolitan areas of the state had rates greater than 1,000 per 100,000 population (i.e., more than one percent of the population in question were infected). African

American men older than 35 years of age had the highest rates compared to other subpopulations in each metropolitan area.

Tuberculosis

TB remains one of the deadliest contagious diseases in the world. It is spread from person to person through the air by droplet nuclei. Droplets are produced when an individual with active TB coughs, sneezes, speaks, or sings, and they may also be produced when using certain methods to obtain specimens for testing in a hospital or laboratory.

In 2006, there were 1,585 cases of TB reported in Texas. Overall, the majority (85 percent) of cases was Hispanic or non-Anglo and 15 percent were reported in Anglo populations. Among non-Anglo populations, Hispanics represented 50 percent of the total 1,585 cases, African Americans represented 22.5 percent, and Asians represented 12.5 percent. Multi-race populations represented less than 0.5 percent, and no cases were reported among Native Hawaiians or other Pacific Islanders.

Foreign-born persons account for a significant percentage of TB morbidity. The percentage of foreign-born individuals with active TB disease has steadily increased over the past 10 years. Foreign-born persons represented 31 percent of TB cases reported in 1996, increasing to 48 percent in 2006. Mexican states that border Texas have high numbers of TB cases, and these numbers contribute to higher TB rates in the 14 contiguous Texas border counties. In 2006, Texas border counties had a TB rate of 12.2 cases per 100,000 residents, which is 97 percent higher than non-border counties, which had a TB rate of 6.2 per 100,000. The total state rate was 6.8 per 100,000 residents.

Mental Illness

Mental illnesses are one of the leading causes of disability in the world. In the United States (U.S.), mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes. According to federal estimates based on epidemiological catchment area studies conducted by the National Institute of Mental Health, as many as 4,147,132 Texans have a mental illness. Among those, an estimated 451,163 adults are considered to be seriously and persistently mentally ill and to meet the mental health priority population definition in Texas (2007). For children, the estimate for the priority population in 2007 was 159,402.

Prevalence of mental illness varies by characteristics such as gender, ethnicity, and age. Nationwide, nearly twice as many women as men suffer from a depressive disorder each year. However, according to the Centers for Disease Control and Prevention (CDC), four times as many men as women commit suicide, with Anglo males committing 73 percent of all suicides in 2002. In 2004 in Texas, Anglo males committed suicide at two and half times the rate of African-American males and

three times that of Hispanic males. The highest suicide rate usually occurs among persons 65 years of age or older.

A complicating factor is the co-occurrence of mental illness and substance abuse. Substance abuse is the most common co-occurring condition among adults with a mental illness, affecting 28 percent of those served with community mental health services in Texas. Treatment of both the mental illness and substance abuse disorder are essential for recovery.

Substance Abuse

Substance abuse is an illness that is progressive, chronic, and relapsing. Biological, medical, psychological, emotional, social, and environmental factors impact substance abuse and dependence behaviors.

According to the 2006 Texas Behavioral Risk Factor Surveillance System (BRFSS), approximately 48.5 percent of Texas adults consumed alcohol in the past month, 14.7 percent reported past-month binge drinking, and 4.6 percent were heavy drinkers. The percentage of heavy drinkers by race/ethnicity was 5.3 percent of Anglos, 3.4 percent of Hispanics, and 2.4 percent of African Americans. According to the 2002-2006 National Drug Use and Health Survey, approximately 6.7 percent of Texans 18 years of age or older reported being past-month users of any illicit drug (e.g. marijuana, cocaine, crack, hallucinogens, inhalants, and heroin). This percentage by race/ethnicity was 7.7 percent of African Americans, 7.5 percent of Anglos, and 4.8 percent of Hispanics.

Among the youth population, the 2006 Texas School Survey of Substance Use found that 24.9 percent of Hispanic secondary students reported past-month binge drinking, compared to 23.9 percent of Anglo students and 11.4 percent of African American students. The percentage of past-month illicit drug use was 14.3 percent of Hispanic students, 12.5 percent of Anglo students, and 10.7 percent of African American students. Hispanic students in the border area reported higher rates of cocaine and Rohypnol consumption than their non-border peers.

Substance abuse is an underlying condition for many individuals in the criminal justice system. It also has a significant impact on an individual's physical health.

Unintentional Injuries

Unintentional injuries are the fourth leading cause of death in Texas and the leading cause of death for people from 1 to 44 years of age. Approximately one-third of unintended injuries are from motor vehicle accidents. According to national figures, injury-related medical expenses were estimated to cost Americans $117 billion, and hospital charges $4.722 billion.

Public Health Emergency Preparedness

Texas faces many different emergency situations, ranging from hurricanes, floods, and tornados to infectious disease outbreaks. In a large state like Texas, with very large and very small communities, planning and response require working closely with local jurisdictions, health departments, and responders, in coordination with the Governor's Division of Emergency Management. Texas has taken an all-hazards approach to preparing health and medical response plans. By taking an all-hazards approach, the state is building an emergency preparedness system that can quickly respond to natural and manmade disasters.

DSHS is the primary agency for coordinating health and medical preparedness and response activities in Texas, such as medical special needs evacuations and public communications about personal health protection. These preparedness and response activities address not only public health and medical services, but also nuclear and/or radiological incidents.

Service Delivery System

Recruitment and Retention of the DSHS Workforce

DSHS has experienced continuous challenges associated with the recruitment of individuals for specific positions across the state. In addition, the agency has difficulty retaining staff in certain positions. Agency leadership anticipates that this situation will be compounded in the future due to:

- Competition from the private sector, federal government, and other state agencies;
- Changes in skills required to fill vacancies as future needs change; and
- The gradual increase in the number of DSHS employees eligible for retirement from state service.

Workforce shortages are not limited to state government, particularly as it relates to health professionals. Community organizations and local governments that are often DSHS contractors are also experiencing difficulty in recruiting and retaining health professionals.

Increased Demand for Agency Services

As the population of Texas grows, so does the demand for public and behavioral health services. These demands often create difficulty in the agency's ability to expeditiously address the needs of individuals who are eligible for DSHS services. In addition, increased utilization of Medicaid and other federal revenue in several program areas requires consistent monitoring of changes to federal funding sources.

Quality Data to Support Decision-Making

DSHS manages numerous databases that are used to generate information for a range of constituents and purposes. DSHS' ability to utilize data elements as a

means to inform decision-making, conduct research, and monitor health status depends on improvements in the effectiveness and efficiency of health registries, disease surveillance, outcome management, and evaluation data.

Opportunities

The agency's focus on public and behavioral health provides DSHS with a broad range of responsibilities and opportunities associated with promoting the health and well-being of Texans. This mission is accomplished in partnership with numerous academic, research, and health and human services stakeholders across the U.S., within Texas, and along the U.S./Mexico border. In addition, service system partners such as DSHS regional offices, DSHS hospitals, Local Mental Health Authorities (LMHAs), local health departments, and contracted service providers serve an important role in working collaboratively to address the current and future challenges faced by the agency. Opportunities for the agency are noted below.

Physical and Behavioral Health Integration

DSHS will work in collaboration with stakeholders to address physical and behavioral health needs through the development of coordinated systems and integrated mechanisms of delivery. The agency will promote the integration of physical and behavioral health services to holistically address the needs of individuals accessing programs provided by DSHS, by its subcontractors, and by federal, state, and local partners.

Strengthen the Behavioral Health Service Continuum

A behavioral health service continuum is comprised of services ranging from prevention and early identification to residential treatment and inpatient hospitalization. DSHS will continue to work with state and local advocates, consumers, families, and other stakeholders to strengthen the availability of a full array of recovery-oriented, community-based services across Texas. DSHS will also explore additional capacity for the prevention and appropriate management of substance abuse and mental illness, as well as investigate innovative approaches and best practices to lessen the effect of substance abuse and mental illness. These approaches may include service integration, as mentioned above, and other strategies intended to direct individuals to more appropriate care settings, thereby avoiding jail, hospitalization, and other more expensive services.

Incorporate Proven Practices

DSHS will incorporate proven practices for effective prevention of health problems, injuries, diseases, and behavioral health disorders and promotion of health and wellness across the lifespan. By applying what is already known about the major causes of disease, disability, and death and how to promote health, it is possible to

decrease negative health outcomes in Texas and reduce their associated costs. Internally and through its network of advisory councils, academic researchers, and other partners, DSHS has the subject matter expertise to translate prevention knowledge into problem-solving in the agency, within the Health and Human Services Enterprise, and statewide.

Preparedness and Continuity of Operations

DSHS will strengthen internal and multi-agency systems for all-hazards preparedness for and response to disasters and health emergencies. Disaster preparedness and response takes place through coordinated networks of partners at local, regional, statewide, and national levels. DSHS has a significant role in the planning and coordination of health and medical preparedness and response. DSHS continues to strengthen its readiness to respond during an emergency and to fulfill the role of coordination, while ensuring the continuity of operations for mission-essential day-to-day functions the agency performs.

Whole-Population Health

DSHS will enhance the methods and means for whole-population health protection and prevention functions. To safeguard the health of the whole population, DSHS, its partners, and the local health systems must have the capacity and skills for detecting and diagnosing threats, exercising prescribed regulatory and consumer protection duties, and developing solutions when identified hazards threaten the health of the public. Trained staff and quality health data are essential to continual surveillance for potential health threats as they emerge in the environment and the population. These health threats include but are not limited to infectious diseases as well as chronic conditions. Ideally, potential health hazards will be detected and addressed early to minimize or avoid their impact as medical problems.

Workforce Issues

DSHS will act to mitigate the health care workforce issues. The same factors causing health care workforce shortages across the U.S., including retirement of current workers and competition from other professional fields, are also factors in Texas. The state has unique needs and particular circumstances that contribute to shortages in specific health, behavioral health, and public health professions. These circumstances include the geographical, cultural, and ethnic diversity of Texas and changing demographics.

As one strategy to help address workforce issues, DSHS will partner with Texas academic institutions to build the base of subject matter expertise and to strengthen coordinated approaches to training and professional development, recruitment, and retention.

Infrastructure

DSHS will work to address the deficiencies of an aging infrastructure to ensure the agency has adequate resources to perform mission-critical functions. This includes assessment of existing building, technology, and fleet resource needs.

- DSHS operates 11 state mental health facility campuses and two health facilities.
  - The facilities comprise 3,032 acres, 552 buildings, and 4.9 million square feet.
  - The average age of the buildings is 55.2 years.
  - More than 84 percent of the total building area is dedicated to patients and patient support.
- Information technology needs for a large state agency include replacing outdated and unreliable hardware and software that pose a significant security and confidentiality risk. Additionally, new technology improves efficiency and may provide better outcomes.
- DSHS operates a fleet of vehicles to support service delivery and patient care. The majority of these vehicles are located across the state at agency health facilities and regional offices.

Collaboration on Important Health Issues

DSHS is committed to working in partnership with each of the various constituents invested in the health and well-being of Texans. This includes serving as a convener, facilitator, participant, and/or leader of various initiatives, activities, or meetings focused on building the capacity of the Texas public/behavioral health system to meet future needs. For example, DSHS convened a wide variety of stakeholders to address community mental health crisis services. Additionally, DSHS is currently involved with a coalition of stakeholders from academia, government, and the public and private sectors to develop and share strategies to address the obesity problem of this state.

Current Activities by Goal: Target Populations, Service Descriptions, and Trends and Initiatives

DSHS Goal 1: Preparedness and Prevention Services

DSHS will protect and promote the public's health by decreasing health threats and sources of disease.

Goal 1 programs focus on the prevention of chronic and infectious diseases, including those associated with public health emergencies, and services for individuals with selected illnesses. Goal 1 also includes epidemiological studies and registries designed to provide the state with basic health care information it needs for policy decisions, to address a particular disease, to establish individual identity, and for research.

Community Preparedness

Target Population

Community preparedness serves the entire Texas population.

Service Description

Preparedness is the state of adequate preparation for a natural disaster, disease outbreak, biologic attack, or other emergency. Planning includes operational guidelines, training on those plans, exercising, and evaluating the plan components. Response is the deployment of necessary resources to address the event.

DSHS coordinates the distribution of grant funds from the CDC and the Office of the Assistant Secretary for Preparedness and Response. These resources are allocated to the statewide network of trauma service areas and local and regional health departments, to:

- Develop, implement, and evaluate preparedness and response planning;
- Enhance surveillance, epidemiology, and laboratory capacities;
- Establish and maintain the Public Health Information Network;
- Develop and implement effective risk communication strategies;
- Assess, coordinate, deliver, and evaluate workforce development packages for key public health professionals, infectious disease specialists, emergency personnel, and other health care providers; and
- Support and ready hospitals and health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies.

DSHS has developed model standards and guidelines to help local jurisdictions prepare emergency response plans with mitigation, preparation, response, and recovery elements. Through this effort and the State Emergency Management Plan, DSHS maintains operational policies and procedures, guidelines, and instructions for the integrated management of health and medical services after a disaster.

Emergency response also includes the DSHS Texas Critical Incident Stress Management Network that is a key component of the Texas Crisis Consortium, which responds to disasters and to the mental health needs of survivors and first responders.

Health Promotion and Vital Records

Target Population

Health Information and Vital Record functions serve the entire Texas population.

Service Description

Intrinsic to public health efforts is the need to provide health information for state and local policy decisions for health status improvement. Key to enabling policy decisions are the vital records and health registries maintained by DSHS, which describe life and health events and analyze and distribute information on health and health care.

Texas Birth Defects Registry

The Texas Birth Defects Registry exists to identify and describe patterns of birth defects in Texas. Tracking the data provides information on what types of birth defects are occurring, how often they are occurring, and where they are occurring. This information can be used to identify the causes of birth defects, implement effective prevention and intervention strategies, and refer affected children and their families to medical and social services.

Cancer Registry

Chapter 92 of the Texas Health and Safety Code requires DSHS to maintain a cancer registry for the state. Functions include maintaining a statewide population-based cancer registry for Texas; analyzing, evaluating, and disseminating cancer data; monitoring the health status of communities; and monitoring changes in cancer incidence over time. The Cancer Registry identifies population groups at increased risk of cancer; investigates concerns of excess cancer; conducts epidemiological cancer studies; evaluates the effectiveness of cancer control initiatives; disseminates cancer information for etiologic research; and performs on-line cancer control planning and evaluation, education, and health services delivery.

Trauma Registry

DSHS maintains a trauma data collection and analysis system, for cases including traumatic brain injuries, spinal cord injuries, major trauma, and drownings/near-drownings. The Texas Emergency Medical Services (EMS)/Trauma Registry also collects, analyzes, and disseminates information on the occurrence of other major injuries in Texas. Examples include traffic, residential, recreational, and occupational injuries, and injuries due to violence, abuse, suicide, and firearms. This data is used to generate public information campaigns to reduce injuries to Texans, allocate EMS funds, determine uncompensated care funds, and develop hospital system development grants. Since coming on-line, the registry has more than quadrupled its volume, receiving nearly 1,500,000 records in 2004. Entities registered with the system now number 960, with 2,977 users.

Center for Health Statistics

The Center for Health Statistics (CHS) collects, analyzes, and disseminates health data and information to improve public health in Texas. CHS activities include: defining data needs and analytical approaches, adopting data standards, providing guidance and education, providing geographic information system (GIS) services, providing forecasting and demographic support, managing and administering the BRFSS, and initiating participation of stakeholders. CHS, through Library and Information Services, provides a comprehensive library program, involving medical and research information, funding information, audiovisuals, records management, and publications management. CHS coordinates the Institutional Review Board, which is responsible for overseeing DSHS-affiliated social, behavioral, educational, and health science research. CHS collects, analyzes, and publishes employment, demographic, supply, and educational trends for health professionals. CHS coordinates with communities and the U.S. Department of Health and Human Services (U.S. DHHS) on federal shortage designations for underserved Texas populations, facilities, and areas. CHS conducts the Annual Survey of Hospitals and collects and reports on hospital charity care and community benefits data. In accordance with Chapter 108 of the Texas Health and Safety Code, CHS collects and reports on inpatient discharge data from hospitals and data from health maintenance organizations to enable individuals in Texas to make informed health care decisions.

Vital Statistics

The DSHS Vital Statistics Unit (VSU) is home to 46 million records of the most important events in Texans' lives: birth, death, marriage, divorce, and adoption. These records are needed to establish identity, citizenship, family relationships, and inheritance. In addition to registering births, deaths, fetal death events, marriage applications, and Suits Affecting the Parent Child Relationship, the Vital Statistics Unit issues certified copies of birth, death, and fetal death records. Other VSU activities include:

- Making changes in vital records because of adoptions, paternity determinations, misspellings, name changes, and other events;
- Serving as the Court of Continuing, Exclusive Jurisdiction Registry;
- Paternity Registry;
- AOP Registry;
- Confirming Marriage & Divorce verifications;
- Investigating fraudulent uses of records, including identity theft; and
- Serving as the Central Adoption Registry.

Border Health

Target Population

Border Health functions serve the two million Texans who live in the border region of Texas.

Service Description

The Office of Border Health (OBH) is charged with promoting and protecting the health of border residents by reducing community and environmental health hazards along the Texas-Mexico border. OBH works in collaboration with communities and U.S. and Mexican local, state, and federal entities.

OBH has field staff in seven border communities (Del Rio, Eagle Pass, El Paso, Harlingen, Laredo, Presidio, and Uvalde) to facilitate a coordinated response to address public health concerns along the border. Staff includes experts in the field of sanitation, environmental health, toxicology, epidemiology, food safety, and policy analysis and development.

To achieve these goals, OBH works with these partners:

- Health and Human Services Commission (HHSC) Office of Border Affairs,
- Seven sister-city health councils,
- U.S.-Mexico Border Health Commission (USMBHC), and
- U.S.-Mexico Governors Health Table.

OBH also coordinates with the USMBHC Health Border 2010 program and community-based projects addressing measurable border health objectives. Through the CDC funding, the Early Warning Infectious Disease Surveillance project enhances border public health preparedness with Mexico (including sharing of surveillance data and providing for appropriately training public health personnel).

Immunizations

Target Population

Immunization services are available for all Texans.

Service Description

DSHS immunization activities improve quality of life and life expectancy by achieving and maintaining an environment free of vaccine-preventable diseases. Vaccines are a cost-effective public health disease control measure. Key strategies to increase vaccine coverage levels are:

- Promoting use of ImmTrac, the statewide immunization registry;
- Providing education on the concept of receiving immunizations in the medical home;

- Encouraging use of reminder/recall systems;
- Educating providers and the general public about immunization services and their public health value; and
- Working with stakeholders to improve implementation of these strategies.

HIV and Sexually Transmitted Disease Services

Target Population

HIV and Sexually Transmitted Disease (STD) prevention efforts in Texas focus on high-risk populations.

Service Description

DSHS HIV/STD Program goals include increasing the number of Texans who know their HIV/STD status, reducing the number of HIV infected persons who have unmet needs for medical care, and increasing community awareness of HIV/STD issues. HIV/STD Program activities include:

- Surveillance;
- Community-based planning;
- HIV/STD prevention services;
- Delivery of medical and support services for persons living with HIV/AIDS, including HIV medications for low-income individuals, and
- Provision of notification and testing services for partners of those diagnosed with HIV/STD.

Prevention efforts include Prevention Counseling and Partner Elicitation (PCPE) and Health Education and Risk Reduction (HERR).

- PCPE services are broadly available statewide via contracts with local health departments and community-based organizations. HIV testing is also offered through these programs, linking HIV-positive clients to care following diagnosis. In 2006, contractors reported a total of 32,400 HIV tests, with 1.22 positives for every 100 tests.
- HERR interventions are designed to assist participants in establishing risk reduction plans and to provide participants with the skills and practices necessary to prevent HIV transmission. In 2006, more than 45,000 HERR contacts were made with persons at high risk for HIV/STD, for using individual-, group-, and community-level behavioral change interventions.

<u>Sexually Transmitted Disease Prevention</u>

STD prevention focuses on screening and disease intervention services. A primary activity is syphilis identification and treatment. Re-emergence of syphilis calls for innovative approaches, such as a “fast track “ triage practice of conducting physical exams on those most likely to be infected, and then providing necessary treatment.

Disease Intervention Specialists interviewed and managed 2,166 early syphilis cases. Disease intervention work relies on informing partners of exposure and getting partners screened and treated if infected. Partner notification services are a cornerstone in all prevention services. In 2006, STD prevention and control programs located, counseled, and tested 4,323 sex and/or needle-sharing partners of HIV-positive individuals, resulting in new diagnosis of 292 HIV cases in 2006. Almost 220,000 people were tested for gonorrhea, resulting in 11,116 positive results, and confirmed treatment on 10,958. Nearly 213,000 people were tested for chlamydia, resulting in 17,149 positives and confirmed treatment on 16,712.

The program also provides funds to local communities to provide medical and social support services for persons living with HIV/AIDS, as well as operating the Texas HIV Medication Program. In 2006, more than 28,000 HIV-positive Texans received HIV-related medical and social support services from providers supported with state and federal Ryan White Program funds. The Texas HIV Medication Program provided 14,909 clients with 259,382 prescriptions in fiscal year (FY) 2006.

Environmental and Injury Epidemiology and Toxicology

Target Population

This program serves the entire Texas population.

Service Description

The Environmental and Injury Epidemiology and Toxicology Services investigate the harmful effects that exposure to hazardous substances may have on human health and quality of life. In addition to administering the Texas Poison Control Centers and the Texas Environmental Health Institute, these programs track trends in:

- Reportable occupational conditions;
- Injuries and trauma;
- Hazardous substance emergency events; and
- Child lead poisoning.

Zoonosis Control

Target Population

Program activities target those who are involved in animal control efforts or monitoring epidemic zoonotic diseases, and the program has benefits for the entire Texas population.

Service Description

Zoonosis Control protects the public's health through prevention and control of diseases transmitted between animals and humans, such as plague, West Nile

virus, rabies, Lyme disease, anthrax, brucellosis, and tularemia. Key services include:

- Using field response teams for emerging or potentially epidemic zoonotic disease occurring naturally or through human activity (Five of the six Category A Bioterrorism agents are zoonotic.);
- Distributing oral rabies vaccine baits to control rabies in certain wildlife species and thereby reducing exposure of people and domestic animals to rabies (Approximately 2.8 million vaccine baits are distributed annually.);
- Inspecting rabies quarantine facilities;
- Developing training materials and implementing training courses for animal control officers;
- Approving euthanasia training courses;
- Distributing rabies preventive medications to bite victims (approximately 1,000 annually);
- Conducting case investigations for zoonotic diseases;
- Submitting specimens for laboratory testing;
- Maintaining a registry of dangerous wild animals and their owners; and
- Public education and technical assistance.

The program also mobilizes community efforts such as pet neutering programs through Animal Friendly grants.

Infectious Disease Control

Target Population

Infectious Disease Control functions serve the entire Texas population.

Service Description

Infectious disease activities are essential in improving the public health response to disasters or disease outbreaks. Key functions that support epidemiological and surveillance activities include:

- Monitoring and tracking more than 45 reportable infectious diseases, including continual surveillance to detect significant changes in disease patterns that might indicate a new common exposure or a bioterrorism event;
- Informing and advising the general public, the medical community, and local and regional health departments on disease control measures to reduce serious illness and death;
- Supporting, collaborating with, and providing technical assistance to local and regional health departments on appropriate methods to monitor diseases, investigate disease outbreaks, and conduct studies to identify newly emerging infectious diseases and their risk factors;

- Educating the general public and medical care providers with current information and recommendations for infectious disease prevention; and
- Developing and implementing strategies and measures to permanently reduce the impact of infectious diseases.

Tuberculosis Services

Target Population

Tuberculosis Services activities serve the entire Texas population.

Service Description

Efforts to prevent and control TB include providing guidance and support to local health departments on how to conduct targeted testing, contact investigations, and outbreak investigations. DSHS works with partners and community-based organizations to establish TB screening programs and to target high-risk populations in areas with a high TB prevalence. The program educates the public on how to prevent TB, and it assures effective disease treatment thorough compliance with effective TB control strategies. In addition, the program:

- Oversees three bi-national projects located on the Texas-Mexico border;
- Coordinates the Ten Against TB initiative, which includes the six Mexican border states and the four U.S. border states;
- Monitors TB screening programs in county jails; and
- Maintains a statewide registry of TB cases and their contacts, including a specialized registry of drug resistant TB cases reported to the state.

The Texas TB Coalition and the Texas TB Epidemiologic Research Consortium are initiatives that seek to identify innovative approaches to TB treatment and management. The CDC's Heartland National Tuberculosis Center (HNTC) provides statewide TB expert consultant services at no cost to health care providers and local health departments. HNTC also develops and implements integrated and specialized curricula for professional training and education in all facets of TB elimination, treatment, case management, and testing strategies.

Chronic Disease Prevention

Target Population

Preventing chronic disease serve the entire Texas population.

Service Description

Community health interventions promote health and prevent incidences of chronic disease or other unwanted health consequences. Specific activities include educating individuals on healthy life choices (e.g., physical exercise and dietary

habits), community outreach, and clinical preventive services. Specific chronic diseases addressed include CVD, cancer, diabetes, Alzheimer's disease, and arthritis. To address these health issues, DSHS engages in the following activities:

- Surveillance and evaluation;
- Community and policy development;
- Health care improvement;
- Health education and community outreach; and
- Prevention interventions targeted for reducing tobacco use, improving nutrition, and increasing physical activity.

Diabetes Prevention and Control

Target Population

The Texas Diabetes Program targets persons with diabetes, persons with prediabetes, and persons at high risk for developing diabetes.

Service Description

Goals of the Texas Diabetes Program are:

- Preventing type 2 diabetes in persons who do not have diabetes;
- Preventing or delaying the onset of type 2 diabetes in persons with prediabetes, gestational diabetes, and/or other high risks;
- Preventing or delaying complications in persons with diabetes; and
- Assisting persons with diabetes in managing their disease and its complications.

To achieve these goals, the Texas Diabetes Program implements a multifaceted approach which includes:

- Community systems changes through local projects that promote safe physical activity and healthful nutrition, and provide local resources for diabetes education for persons with diabetes and health care providers;
- Worksite interventions to promote wellness among employees to develop a healthier, supportive work environment;
- Local media contacts, to promote lifestyle change messages, prevent onset of diabetes and its complications, and provide links to local resources;
- School-based interventions to ensure implementation of coordinated school health and diabetes care in schools; and
- Health care systems changes to promote quality care and prevention efforts for providers, payers, and educators.

Nutrition, Physical Activity and Obesity Program

Target Population

The Nutrition, Physical Activity and Obesity Program (NPAOP) targets both general and special populations in communities throughout the state.

Service Description

NPAOP works to reduce the burden of death and disease related to obesity in Texas. The program administers an obesity-focused cooperative agreement from the CDC, monitors the nutrition and physical activity status of Texans to identify emerging problems, provides training and technical assistance to health professionals, and facilitates community-based coalition development. Specific activities include:

- Development and oversight of the *Strategic Plan for the Prevention of Obesity in Texas*;
- Development of a model worksite wellness program for state agencies;
- Staff support for the Interagency Obesity Council, comprised of the commissioners of DSHS, the Texas Department of Agriculture, and the Texas Education Agency;
- Oversight of CDC-funded pilot programs in Fort Stockton and Corpus Christi; and
- Policy and activity coordination with DSHS regional nutritionists.

Abstinence Education

Target Population

Abstinence education efforts are targeted to adolescents, parents, school personnel, and health professionals.

Service Description

The Abstinence Education Program provides educational programs via contract services to priority populations in order to prevent teen pregnancy and STDs. Priority populations include youth, parents, and health professionals.

Abstinence Education Program services are designed to:

- Decrease the pregnancy rate among teens;
- Reduce the proportion of adolescents engaged in sex;
- Reduce the incidence of STDs in adolescents; and
- Increase the number of youth and adults served through abstinence education.

Currently, 25 contractors across the state implement abstinence-only curricula for at-risk youth, both in and out of school. Programs are also provided for parents and health professionals. Contractors include community-based organizations, faith-based organizations, schools, and health departments. DSHS staff provides training, technical assistance, and quality assurance activities.

Children with Special Health Care Needs Services Program

Target Population

The Children with Special Health Care Needs (CSHCN) Services Program serves individuals who meet certain medical and income eligibility. The Program pays for health care benefits and services not covered by other payers. Support services also target the families of these children.

Service Description

The CSHCN Services Program supports family-centered, community-based strategies for improving the quality of life for eligible children and their families. The CSHCN Services Program covers health care benefits for children with extraordinary medical needs, disabilities, and chronic health conditions.

Health care benefits include a broad array of medical care and related services. The program contracts with community-based organizations in many parts of the state to provide case management, family supports, community resources, and clinical services. The CSHCN Services Program also provides case management services through DSHS staff based in eight 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 these children.

Kidney Health Care

Target Population

The Kidney Health Care (KHC) program serves persons with end stage renal disease (ESRD) who meet specific income and other eligibility requirements.

Service Description

The KHC Program provides medical, drug, and transportation services to persons diagnosed with ESRD. Medical services (dialysis and access surgery) are provided through contractual agreements with hospitals, dialysis facilities, and physicians. The KHC Program provides payment for covered outpatient drugs and limited reimbursement for travel to receive services. In addition, the program pays monthly premiums for Medicare Parts A and B for eligible Medicare recipients.

In 2006, the program completed the rollout for the Medicare Part D (prescription drug coverage) Enrollment and Education Grant with the Department of Aging and Disability Services. The initiative provided education and outreach activities to program recipients. KHC also implemented payment of Medicare Part D premiums and associated Part D drug costs, including deductibles, co-insurance, and gap coverage for recipients enrolled on the plan. The payment of the 20 percent co-insurance costs for immunosuppressive drugs under Medicare Part B for recipients with a kidney transplant was also initiated.

Laboratory Operations

Target Population

The DSHS public health laboratory services serve all Texans.

Service Description

The DSHS public health laboratory provides analytical, reference, research, training, and educational services related to laboratory testing. Laboratory services include the following:

- Analytical testing and screening services for children and newborns;
- Women's Health Laboratory specialty services for preventive women's health and infectious disease screening;
- Availability as a resource for the education and training of laboratory professionals;
- Diagnostic, reference, and surveillance testing for physicians, hospitals, reference laboratories, and DSHS programs in microbiology;
- Analytical chemistry testing to support the U.S. Environmental Protection Agency Safe Drinking Water Program and other programs supporting public health environmental programs;
- Quality assurance and oversight;
- Certifying milk testing; and
- Providing chemical threat and bio-threat laboratory testing and training as part of the Preparedness Laboratory Response Network.

Regional & Local Public Health Services and Systems

Target Population

The local and regional public health system serves all Texans.

Service Description

Local public health agencies and DSHS health service regions provide essential public health services. The purpose of the local and regional public health system is to safeguard Texans' health by performing prevention, protection, and regulatory

functions and effectively responding in an emergency or disaster. In the absence of local health departments or authorities, DSHS health service regions perform critical functions related to public health and preparedness, as well as working to reduce or eliminate health disparities in the state. A number of priority public health issues are addressed by the regional and local public health system, including:

- Activities associated with assessment of health disparities, health education, and promotion;
- Working with communities and local officials on building local public health services;
- Enforcing local and state public health laws;
- Identifying populations with barriers to health care services; and
- Evaluating public health outcomes.

DSHS Goal 1 Trends and Initiatives

Hospital Associated Infections Reporting

From 130,000 to 160,000 infections associated with health care are expected annually in Texas at an estimated cost as high as $2 billion. Senate Bill (S.B.) 288, 80th Legislature, Regular Session, 2007, addressed this issue by requiring DSHS to establish a Hospital Associated Infections (HAI) reporting system. In addition, this legislation charges DSHS with developing and publishing a summation of the infections reported by health care facilities. The following are additional DSHS responsibilities contained in S.B. 288:

- Establishing an advisory panel,
- Providing education and training for health care facility staff, and
- Providing accurate comparison of HAI data to the public to help individuals make informed decisions about choosing health care facilities.

Pandemic Influenza Preparedness

Texas preparations for pandemic influenza have been ongoing. In Texas, influenza surveillance activities continue to expand—from identifying Texas illnesses to monitoring global events. Texas began developing its current Pandemic Influenza Plan in 2002. This plan, which complements the revised World Health Organization plan and the U.S. plan, includes:

- Guidance to local health departments for working with community leaders;
- Considerations surrounding allocation and distribution of vaccines and antivirals;
- Updated designs for mass vaccination clinics based on real-time, full-scale exercises; and
- Development of information toolkits for health care providers and community leaders.

The Texas plan was developed working in concert with public and private sector partners at the local, state, and federal levels.

Increasing Vaccine Coverage Levels

Immunizations are a priority in Texas. DSHS will continue to provide leadership to the state in promoting best practices in immunization services. Activities support and build on strategies consistent with high vaccine coverage levels to:

- Promote the use of registries;
- Promote the use of reminder/recall systems;
- Promote public and provider education;
- Promote the medical home concept; and
- Promote the use of partnerships within the community to improve each of these strategies.

DSHS implemented House Bill (H.B.) 1921, 78th Legislature, Regular Session, 2003, and is currently implementing Article 12 of S.B. 11, 80th Legislature, Regular Session, 2007, to improve ImmTrac, the statewide immunization registry. ImmTrac continues to improve, and DSHS staff is working with stakeholders to identify and prioritize improvements.

CDC conducts the National Immunization Survey (NIS) annually, and the results are used to estimate vaccine coverage levels for all states and some cities. The NIS data for 2006 indicate Texas' vaccine coverage level to be 74.7 percent for the 4:3:1:3:3:1 measure (4 doses of diphtheria, tetanus, and pertussis vaccine; 3 doses of polio vaccine; 1 dose of measles, mumps, and rubella vaccine; 3 doses of hepatitis B vaccine; 3 doses of *haemophilus influenza* type B vaccine; and 1 dose of varicella vaccine). The national average for 2006 was 77.0 percent.

The latest data shows low completion rates for children receiving the fourth dose of DTaP vaccine. A media campaign targeting the general public was conducted in the fall of 2007, and a provider education campaign will be conducted during 2008, focusing on the fourth dose of DTaP.

HIV/AIDS Services

Medication costs for treating HIV continue to rise. At the same time, these medications have resulted in tremendous gains in life expectancy and quality of life. The number of persons living with HIV/AIDS in Texas increased by 33 percent from 2002 to 2006. Quality of life continues to improve for persons with HIV, with advances in medical management and treatment. Antiretroviral medications reduce the likelihood of virus transmission as they reduce viral counts in infected individuals. Improved physical health in general correlates with improved mental health. However, evidence indicates that more than half the clients receiving care have strong needs for mental health and/or substance abuse treatment. These needs are typically greater than the current capacity of community providers in most areas of

Texas, and they are complicated by the stigmas associated with HIV infection, mental illness, and substance abuse.

Another emerging issue is the CDC recommendation for universal HIV testing. This recommendation will be a factor to consider in future policy discussions on DSHS services.

Prevention and Control of Obesity

Since the release of the *Strategic Plan for the Prevention of Obesity in Texas* in April 2006, members of the original Statewide Obesity Taskforce and new partners were convened. Taskforce members were re-surveyed to streamline Texas target measures related to obesity prevention from a total count of 43 to 19 targets. The targets are based on available data sources and will serve to better track the implementation of the state plan and the effectiveness of current efforts.

DSHS continues to monitor state and regional-level data and make recommendations regarding the best interventions and approaches needed across the agency to combat obesity in Texas.

Growth of Laboratory Services and Changing Technology

The Public Health Laboratory Section provides a wide range of services including newborn screening, clinical chemistry, prenatal testing and DNA diagnosis, microbiological testing, environmental testing, and the identification of bioterrorism and chemical terrorism agents. In 2006, the laboratory reported results on more than 2.0 million specimens submitted. As the Texas population continues to grow, so does the number and kinds of laboratory tests requested. Due to improved technology from FY 2002 to FY 2006, there has been a significant increase in use of molecular technology for testing specimens for infectious agents and genetic markers. These methods provide faster, more accurate test results than many of the traditional methods, resulting in more timely interventions to control outbreaks or assure treatments. However, the cost of these newer methods is higher than the traditional methods.

Implementation of Laboratory Information Management Systems (LIMS) for a new Public Health LIMS will be completed in 2008. The Public Health LIMS will be Public Health Information Network compliant, will interface with CDC's National Electronic Disease Surveillance System, and will integrate with an updated billing system. The new technologies coupled with the new LIMS will allow the Laboratory to provide efficient, cost-effective services to the state of Texas.

Glenda Dawson Donate Life-Texas Registry

The Donate Life-Texas Registry provides Texans with a convenient way to register their intent to become organ, tissue, or eye donors upon their death. Registered organ procurement organizations, tissue banks, and eye banks may search the Internet-based registry on a case-by-case basis. Potential donors may register on-

line or in person at the Texas Department of Public Safety (DPS) driver license offices.

REAL ID Act of 2005

Congress adopted the REAL ID Act of 2005, Public Law 109-13, Title II, as part of the Emergency Supplementation Appropriations Bill for Defense. Title II of the REAL ID Act repealed provisions that established a cooperative state-federal effort to devise federal standards for driver's licenses, and Title II of REAL ID specified those standards. The U.S. Department of Homeland Security (U.S. DHS) announced final rules on January 11, 2008. The final rules allow for a waiver process for states to extend the deadline until 2011.

In addition to specific information and features that must be included on driver's licenses and state identification cards, states must require certain identity documents and must verify the validity and completeness of each document to be presented.

The principal workload and resource impact of this legislation rests on the Texas DPS. However, DSHS will receive significant verification inquiries for birth certificates on behalf of agencies issuing driver's licenses. This new requirement will generate additional workload and information technology costs for the state to be compatible with the system put in place by the federal government.

DSHS Goal 2: Community Health Services

DSHS will improve the health of children, women, families, and individuals, and enhance the capacity of communities to deliver health care services.

Goal 2 programs seek to ensure that Texans have access to the most fundamental health services, prevention, and treatment across the state, through contracts with providers. Those services include primary health care, mental health care, and substance abuse services. Under this goal, DSHS also works through the WIC program to ensure that good nutrition is accessible to Texans who are younger than five years of age or are women who are pregnant, breastfeeding, or post partum. Finally, DSHS works to build health care capacity in communities by providing technical assistance and limited funding to organizations applying for certification as Federally Qualified Health Clinics (FQHC), EMS providers, and state trauma centers.

Women, Infants and Children & Farmer's Market Nutrition Programs

Target Population

The Women, Infants and Children (WIC) program and the Farmer's Market Nutrition Program (FMNP) provide services to a caseload approaching one million pregnant,

breastfeeding, and postpartum women, and children birth through 4 years of age who meet the income and other eligibility requirements.

Service Description

The WIC program is primarily administered through contracts with local health departments, cities, counties, hospital districts, hospitals, community action agencies, and other non-profit entities. Women, infants, and children participating in the WIC Program receive nutrition education, breastfeeding support, referrals to health care providers, and nutritious supplemental foods. Some WIC agencies provide immunizations free of charge to WIC clients. The WIC nutrition services are intended to be an adjunct to good health care during the critical times of a child's early growth and development, to prevent health problems and to improve consumers' health status. The WIC program strives to achieve a positive change in dietary habits, with the goal that this change will continue after participation in the program has ceased.

The FMNP is administered through contracts with farmers' markets across the state. WIC clients receive coupons redeemable at farmers' markets for fresh fruit and vegetables.

Women's Health Programs & Services

Family Planning

Target Population

The DSHS Family Planning program serves women of child-bearing age and men who meet specific income and other eligibility criteria.

Service Description

DSHS administers and facilitates statewide, coordinated delivery of preventive, comprehensive health care services to low-income women and men. The purpose of the program is to reduce unintended pregnancies, improve health status, and positively affect future pregnancy outcomes. The program also funds special projects across the state, such as providing education and early intervention services to adolescent males at risk of becoming fathers, and promoting the integration of HIV screening during family planning visits.

Services include comprehensive health assessments, laboratory testing (including Pap tests), screening for diabetes and anemia, contraception, and referrals for prenatal and other medical care. Contractors represent a range of health care entities, including local health departments, hospital districts, non-profit organizations, FQHCs, and university-based clinics.

Breast and Cervical Cancer

Target Population

This program serves women younger than 65 years of age who meet income and other eligibility requirements. Priority is given to women from 50 to 64 years of age for breast cancer screenings and women from 18 to 64 years of age who have never been screened or have not been screened in the past five years for cervical cancer.

Service Description

DSHS administers Breast and Cervical Cancer Control activities intended to reduce breast and cervical cancer mortality. The program ensures statewide delivery of breast and cervical cancer screening, diagnostic services, case management, and surveillance services. DSHS contractors provide a variety of services, including clinical breast examinations, mammograms, Pap tests, pelvic examinations and diagnostic and case management services for women with abnormal test results.

Contractors include local and regional health departments, community health centers, FQHCs, hospitals, family planning agencies, and university-based clinics. Contractors are responsible for assisting women diagnosed with breast or cervical cancer who are potentially eligible for Medicaid under the Breast and Cervical Cancer Treatment Act. In 2007, the Legislature provided funding and enhanced policy changes that will allow more women to receive Medicaid services under the Treatment Act.

Title V, Maternal and Child Health Block Grant

Target Population

Title V programs serve women and their families at or below 185 percent of the federal poverty level (FPL) who are not eligible for Medicaid or the Children's Health Insurance Program (CHIP).

Service Description

The Texas Title V Program provides funds for a wide range of activities supporting preventive and primary care services for pregnant women, mothers, infants, children, and adolescents. Through a competitive process, contracts are awarded to health care organizations and professionals across the state to provide family planning, dysplasia detection, prenatal care, well-baby care, laboratory services, and case management to families.

A statewide Violence against Women Plan was developed through a CDC grant. Title V is working with the Office of the Attorney General, the Texas Association Against Sexual Assault, and other stakeholders to plan, implement, and evaluate sexual violence prevention and education efforts in Texas.

Many of the Texas Title V Program's infrastructure-building and population-based activities include a focus on mental health and substance abuse. Staff works with partners throughout the agency and with external stakeholders on various behavioral health issues.

Title V also supports population-based services, such as screening Texas children for health needs related to vision and hearing, spinal abnormalities, newborn hearing loss, and newborn diseases. Additionally, children's health programs promote adolescent health, car seat safety, abstinence in teens, and fluoridation of drinking water supplies across Texas.

In 2007, the Title V program funded 16 contractors in targeted areas of the state to address root causes of teen pregnancy, low birth weight, sexually-transmitted diseases, and adequacy of prenatal care in higher-risk counties

Child/Adolescent Health

Target Population

Child/adolescent health programs in Texas serve low-income children and adolescents, including parents as appropriate, as determined by specific program eligibility requirements.

Service Description

Child and adolescent health services include comprehensive and preventive health care administered through a variety of programs and funding sources. Related activities also include designing and implementing federally mandated outreach materials to educate and train parents, child care providers, and early childhood professionals on health and safety issues.

<u>Newborn Screening</u>

Beginning in late 2006, DSHS began the expansion of the panel of disorders screened in newborns in Texas from seven to twenty-eight disorders. The goal of the program is to decrease the morbidity and mortality of infants born in Texas by providing:

- Accurate, fast, and high quality screening laboratory analysis for practitioners;
- Follow-up case management services;
- A statistical review of the program; and
- Outreach education.

DSHS also began notifying families of children identified with the sickle cell trait and expanded the coverage of benefits for uninsured children identified with an abnormal screen in order for them to access confirmatory testing or treatment.

Oral Health

DSHS Oral Health Program provides preventive dental services to children of preschool and elementary school age. Services include dental screening exams, the provision of dental prophylaxes, topical fluoride application for pre-school age children, and the placement of dental sealants in children of elementary school age. DSHS Oral Health works collaboratively with Head Start grantees, schools of dental hygiene, faith-based organizations, community-based organizations, organized dentistry and dental hygiene, and other interested parties, to leverage available resources for the provision of preventive and therapeutic dental services to the target populations.

Texas Health Steps

Texas Health Steps (THSteps) is the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Texas children from birth to 21 years of age who are on Medicaid. THSteps services include regular medical and dental check-ups and treatment. This preventive focus helps to identify and prevent health and dental problems. Ongoing outreach and education efforts build the capacity of communities to deliver health care services and provide useful information for service recipients. In 2007, DSHS launched a provider education campaign that includes 16 free continuing on-line courses.

Case Management for Children and Pregnant Women

The Case Management for Children and Pregnant Women Program provides training to approved case management providers. Regional staff provides direct case management services across the state to children with special health care needs and their families, and to children and pregnant women.

Personal Care Services

In 2007, DSHS, at the direction of HHSC, began determining eligibility for a new Medicaid benefit, Personal Care Services (PCS). Children from birth through 21 years of age are eligible for PCS if they have a health or mental health condition that limits their activities of daily living. DSHS Regional Case Management staff performs a comprehensive assessment, determine eligibility, and authorize hours of attendant services.

Genetics Program

The Genetics Program contracts for direct genetic services and population-based genetic projects. Genetics staff educates health care providers, consumers, and the public about the benefits of genetic services.

Primary Health Care

Target Population

The program serves Texas residents at or below 150 percent of the FPL who are not eligible for other programs that provide the same services.

Service Description

Primary Health Care ensures the delivery of basic health care services through contracts with providers. Services must include six priority diagnosis and treatment services: emergency care; family planning; preventive health, including immunizations; health education; and laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services. Other services may include nutrition, health screening, home health care, dental care, transportation, prescription drugs and devices, durable supplies, environmental health, podiatry, and social services. On an annual basis, contractors establish local service delivery plans targeting their communities' priority health issues based on needs assessment findings and input from advisory committees.

County Indigent Health Care Program

Target Population

The County Indigent Health Care Program serves Texas residents with income at or below 21 percent of the FPL and who are not categorically eligible for Medicaid.

Service Description

The program is locally administered by counties, public hospitals, and hospital districts, with program oversight assigned to DSHS. Program staff assists counties in meeting their statutory indigent health care responsibilities by providing technical assistance and state funding for a portion of the counties' indigent health care costs.

Community Mental Health Services for Adults and Children

Target Population

The adult mental health priority population consists of adults who have severe and persistent mental illnesses and who require crisis resolution or ongoing and long-term support and treatment, and any individual who is believed to be in a mental health crisis and requires stabilization.

The population targeted for Resiliency and Disease Management (RDM), described below, is a subset of the priority population in accordance with H.B. 2292, 78th Legislature, Regular Session, 2003. RDM targets those persons with schizophrenia, bipolar disorder, and other disorders who have not responded to less intensive treatment. Those who are not prioritized for RDM are eligible for crisis services and/or short-term services.

The children's mental health priority population consists of children from 3 to 17 years of age with a diagnosis of mental illness and who:

- Have a serious functional impairment;
- Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; and
- Are enrolled in special education because of a serious emotional disturbance.

Service Description

As the state mental health authority, DSHS manages performance contracts with 38 community mental health centers to deliver services using evidence-based approaches. These models include Assertive Community Treatment, Supported Employment, Supported Housing, and the Wraparound process. The RDM Initiative uses a disease management approach to direct evidence-based services and supports to service recipients. Proper treatment of serious mental illness is resource-intensive, and RDM is intended to provide treatment in sufficient amounts to facilitate recovery.

Substance Abuse Services

Target Population

Substance abuse prevention and treatment services are available to adult and youth populations identified as having or showing signs of a substance abuse problem. Treatment services are available to persons who meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition criteria for substance abuse or dependence and are medically indigent. In addition, state and federal law specifies priority risk groups, including: identified substance abusers infected with HIV and persons at risk for HIV, persons who use intravenous drugs, and women with substance use disorders who are pregnant and/or parenting or have had their children removed from the home because of a substance use disorder.

In FY 2007, 61,005 persons were served in DSHS-funded substance abuse treatment programs. Of these persons, approximately 12.6 percent (7,660) were younger than 18 years of age. Of the total persons served in the treatment programs, 42.1 percent were Anglo, 34.3 percent were Hispanic, 17.3 percent were African American, and 6.4 percent were of other race or ethnicity.

Service Description

A service continuum has been developed to address substance use and abuse. Services are delivered through community organizations that contract with the state. The service continuum ranges from universal prevention to treatment, which is provided in inpatient, residential, and outpatient settings. Prevention services are

delivered using the Institute of Medicine's universal, selective, and indicated prevention classifications.

Outreach, Screening, Assessment, and Referral services identify persons with substance abuse problems, evaluate their needs and preferences, and link them with appropriate treatment and support services. These services are provided in conjunction with focused, short-term interventions to motivate and prepare individuals for treatment or self-directed change in behavior when more intensive treatment is not indicated.

Approximately 85 percent of Texas' funding for substance abuse services in FY 2005 was provided by federal block grant funds which include federal requirements for priority risk populations.

NorthSTAR

Target Population

NorthSTAR services are for Medicaid-eligible and other individuals who meet eligibility criteria for community mental health or substance abuse services, and who reside in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties.

Service Description

NorthSTAR is an integrated behavioral health project that blends funding (Medicaid, mental health and substance abuse block grant funds, and state general revenue) from HHSC and DSHS to provide managed behavioral health care (mental health and substance abuse) services.

Tobacco Prevention and Control

Target Population

Tobacco prevention and control efforts benefit all Texans.

Service Description

The mission of the DSHS Tobacco Prevention and Control program is to:

- Reduce the health effects and economic toll of tobacco by preventing tobacco use by youth;
- Promote tobacco cessation among adults and youth;
- Eliminate exposure to secondhand smoke; and
- Identify and eliminate tobacco-related health disparities among diverse and special populations.

In 2006, the Tobacco Prevention and Control Program was moved from the Chronic Disease Prevention Branch and integrated into the Mental Health and Substance

Abuse Services Division at DSHS. This move was designed to leverage the delivery systems for substance abuse prevention and public health services.

DSHS has implemented a variety of initiatives to prevent tobacco use, including a public awareness education campaign focusing on tobacco prevention and the Texas Tobacco Law for teens (13-17 years old) and adults. DPS has partnered with DSHS to expand efforts statewide by displaying educational messages and showing public service announcements about the Texas Tobacco Law in DPS offices. With support from DSHS, several counties (including Harris, Fort Bend, Montgomery, and Jefferson) have implemented comprehensive tobacco programs, where data show a 36 percent reduction in grade tobacco use by 6th- through 12th-graders (approximately 55,000 fewer youth tobacco users) and a 19 percent reduction in adult smokers (approximately 90,000 fewer adult smokers). Intervention strategies include community/school programs, media awareness, enforcement of tobacco laws, and implementation of cessation resources.

Community Capacity Building

Target Population

These community capacity programs benefit all Texans.

Service Description

DSHS provides a variety of services to develop and enhance the capacities of community clinical service providers and regionalized emergency health care systems in Texas.

Federally Qualified Health Clinics Infrastructure Grants

Increasing the numbers of health care professionals and access to health care services in medically underserved areas of Texas is the purpose of the FQHC Infrastructure Grants. These grants provide resources to assist in the development of new or expanded FQHCs.

Recruitment and Retention of Health Professionals

The Texas Office of Primary Care oversees cooperative agreement funding from the U.S. DHHS, Health Resources and Services Administration. This funding provides support for recruitment and retention of health professionals across the state. The program focuses on clinics that are located in health professional shortage areas and medically underserved areas. The federal funds also support activities that measure access to health care services and designate these as provider shortage areas and medically underserved communities.

The J-1 Visa Waiver program, which places foreign physicians in medically underserved areas, helps communities develop the capacity to provide medical services to their citizens.

EMS and Trauma Systems

DSHS builds community capacity to ensure the public's safety through EMS/trauma systems across the state. To ensure the availability of prompt and skilled emergency medical care, regional EMS/trauma systems work to decrease mortality and improve the quality of emergency medical care. Emergency medical care is enhanced through the administration of grant programs targeting EMS providers, regional advisory councils, and hospitals.

DSHS Goal 2 Trends and Initiatives

Mental Health Transformation

DSHS continues to coordinate the implementation of the Mental Health Transformation State Incentive Grant, awarded to Texas by the federal Substance Abuse and Mental Health Services Administration in 2005. The grant is for approximately $2.7 million annually over five years, and it is overseen by the Transformation Working Group comprised of 14 state agencies, consumer and family member representatives, the Office of the Governor, and two state legislators. Accomplishments under the grant have included the development of a Comprehensive Mental Health Plan for Texas, an annual consumer conference, a symposium in 2007 featuring national speakers on mental health transformation, the funding of eight community collaboratives to work on transformation at the local level, and the formation of six interagency workgroups developing strategies to meet the goals set forth in the Comprehensive Mental Health Plan.

Crisis Services Redesign

Texas is facing a growing demand for mental health crisis services. During the 80th Legislative Session, DSHS requested and received $82 million to implement a statewide redesign of crisis services. Implementation of this redesign will focus on ensuring statewide access to competent rapid response services, helping clients avoid hospitalization, and reducing demand for transportation.

Within the framework provided by the state, local decision-making will play a significant role in determining the final distribution of dollars among the identified service categories. The first priority for these funds will be ensuring a minimum level of core crisis services including crisis hotlines, mobile outreach services, and outpatient crisis services. Once the minimum level of core services have been achieved, funds will be used to establish or expand additional crisis services.

A portion of the funds available for crisis redesign will be awarded on a competitive basis to local communities to develop psychiatric emergency services and other jail and hospital diversion projects, as well as pilots for outpatient competency restoration services.

Local Planning and Network Development

The Local Planning and Network Development initiative implements a new process for local planning, focusing on the development of a robust network of local mental health service providers. The framework for this process is established in statute, which requires LMHAs to develop a Local Network Development Plan that reflects local needs and priorities and maximizes consumer choice and access to qualified providers. This initiative was known as the "Provider of Last Resort," due to the provisions in H.B. 2292 requiring this direction. The rule was adopted through a negotiated rule-making process and was codified in law by H.B. 2439, 80th Legislature, Regular Session, 2007. This collaborative approach establishes a standardized process for planning and developing a provider network.

Frew v. Hawkins Implementation

A class action lawsuit, now known as *Frew v. Hawkins*, was filed against the State of Texas in 1993, alleging the State did not adequately provide Medicaid EPSDT services. A Consent Decree was signed by the parties in 1996 and remains in effect. Parties negotiated an agreed set of corrective actions, and in 2007 the court approved the agreed corrective action orders (CAO). DSHS participates in the implementation of most of the corrective orders and have direct involvement in five of them. H.B. 15, 80th Legislature, Regular Session, 2007, appropriated $150 million to help fund the CAOs and develop and implement strategic initiatives to improve access and services. DSHS is working with HHSC to propose strategic initiatives to the External *Frew* Advisory Committee and the *Frew* Interagency Workgroup. The groups have recommended implementing several strategic initiatives for which DSHS is the primary agency, and potential initiatives continue to be proposed. The initiatives are intended to result in fundamental improvements in the Medicaid program. In addition, DSHS worked with HHSC in 2007 to increase Medicaid reimbursement rates related to health care services for children, most specifically around dental care.

Women's Health Program

A Medicaid waiver program that provides low-income, uninsured women with gynecological exams, related health screenings, and contraception was implemented by HHSC in January 2007. The goal of the Women's Health Program is to reduce unintended pregnancies and avert costs related to Medicaid births. To qualify for the program, women must be from 18 to 44 years of age and seeking family planning services, have a net family income at or below 185 percent of the FPL, and be a U.S. citizen or eligible immigrant. The DSHS Family Planning program supports the Women's Health Program by screening and enrolling eligible clients and reimbursing contractors for family planning services not covered by the Women's Health Program.

1915(c) Medicaid Waiver: Living Independently through Family Empowerment

HHSC and DSHS are planning to submit a 1915(c) Medicaid Waiver request to the federal government. If approved, the program, called Living Independently though Family Empowerment (LIFE), will allow more flexibility in the funding of intensive community-based services and supports for children with serious emotional disturbances (SEDs) and their families. HHSC and DSHS have worked collaboratively to develop the waiver and have sought input throughout the process from a broad array of stakeholders.

The waiver is designed to reduce Medicaid psychiatric hospital expenses for children with SED by providing community-based services. The goals of the proposed waiver include:

- Providing a more complete continuum of community-based services and supports for children with SED;
- Preventing or reducing inpatient psychiatric admissions for children with SED;
- Preventing entries into and returns to the foster care system;
- Reducing out-of-home placements by all child-serving agencies; and
- Improving the clinical and functional outcomes of youth and their families.

The LIFE waiver would initially be piloted in a limited geographic area and would serve up to 300 youth younger than 19 years of age. DSHS and HHSC plan to submit the LIFE waiver request to the federal Centers for Medicare and Medicaid Services (CMS) in June 2008. Preparatory work (including staffing, provider contracting, and training) would be completed by June 2009. The waiver, if approved by CMS, is estimated to start enrolling children in September of 2009.

Comprehensive Integration Planning

In FY 2008, DSHS initiated a planning process designed to assess the agency's capacity and readiness for integrating primary and behavioral health services. As a result, a plan will be developed to serve as the foundation for integrating services that address overall health and well-being. As part of this effort, DSHS will pursue opportunities to work in collaboration with other state and local entities involved in similar initiatives. Methods for achieving integration will focus on improved service coordination and adoption of approaches that holistically address the needs of individuals receiving DSHS-funded services.

Clinical Management for Behavioral Health Services

The Information Technology capital project, Clinical Management for Behavioral Health Services, is underway, with goals to define consolidated business processes and to update software applications to enable successful provision of behavioral health services to Texans. This new system will provide a complete electronic health record of a client's progress through the mental health and substance abuse

services system to ensure continuity of care and accountability for purchased services.

Jail Diversion

Through a partnership with the Texas Correctional Office on Offenders with Medical or Mental Impairments, the mental health system coordinates care for persons with mental illness who become involved with the criminal justice system. Collaborative efforts in this area include the development of jail diversion strategies so that persons with severe mental illness may avoid contact with the criminal justice system where appropriate. Implementation of S.B. 839, 80th Legislature, Regular Session, 2007 will result in real-time sharing of information between the DPS database and the DSHS client record system, to help identify persons who have a history of mental health issues, in order to divert them to appropriate services.

Texas Recovery Initiative

DSHS has begun a multi-phased project called the Texas Recovery Initiative, to gather information and develop recommendations for addiction treatment protocols that are evidence-based and recovery-oriented. This project is being developed in conjunction with providers, stakeholders, academics, recovery support groups, and other state agencies. The first phase, completed in October 2007, included a series of community and workgroup meetings held in Dallas, Lubbock, and Houston; stakeholder feedback was gathered through an on-line survey. In the second phase, a Task Force of invited stakeholders met three times in Austin, in October, November, and December. The Texas Recovery Initiative Task Force Report is in development and will be posted on the DSHS website.

Electronic Benefits Transfer

The WIC program's major initiative to enhance client services and improve efficiencies at the state and local level has two main components: implementation of an electronic benefits transfer system for food delivery and enhancement/upgrading of the statewide automation system, the WIC Information Network (WIN). Continued successful and optimal operation of WIN is critical for delivery of program food benefits to more than 900,000 clients monthly.

New Women, Infants and Children Food Package

The U.S. Department of Agriculture issued an interim final rule in December 2007 to align WIC food packages with the 2005 Dietary Guidelines for Americans and infant feeding practice guidelines of the American Academy of Pediatrics. The interim final rule largely reflects recommendations made by the Institute of Medicine. Current food packages have remained essentially the same since 1980. The revised food packages add several categories, including fruits and vegetables for children and women, jars of fruits and vegetables for infants, and whole grain bread and other whole grain options. The revised packages reduce some existing food allowances,

including milk, eggs, and juice. States must implement the provisions by August 2009.

Teen Pregnancy Prevention

Teen pregnancy, including multiple births to young mothers, is a serious public health issue in Texas. DSHS is attempting to decrease the pregnancy rate among teens, particularly those from 15 to 17 years of age, by implementing the following initiatives:

- Federal funding to six adolescent pregnancy prevention initiatives in El Paso, Potter, Hale, Terry, Harris and Nueces counties.
- Federal funding for abstinence-only education. Funds are disseminated to approximately 25 contractors across the state to provide educational materials, usually in a school-based setting. DSHS also provides a portion of the funds to the 20 regional Education Service Centers who support existing abstinence education providers or directly provide training and materials to parents and teachers.
- Federally funded family planning services. Teens make up approximately 17 percent of approximately 270,000 total clients served per year. In addition to medical services, teens are counseled on family involvement in the teen's decision to seek family planning services and on resisting attempts to be coerced into sexual activity. Special projects include a focus on young men at risk of becoming fathers.

In October 2007, DSHS convened a group of experts to identify the effective components of a pregnancy prevention program for Hispanic adolescents. Meeting participants included public health policy-makers, researchers, clinicians, social scientists, and others who are interested in reducing pregnancy risks among adolescents in Texas. A significant portion of the discussion focused on helping parents understand how to communicate with their children to encourage them to delay sexual activity.

Tobacco Prevention and Control Coalition Grants

Six grants were recently awarded through a request for proposals (RFP) to local coalitions to provide community-planned, evidence-based tobacco prevention and control activities. The 2008-09 General Appropriations Act (Article II, Department of State Health Services, Rider 66, H.B. 1, 80th Legislature, Regular Session, 2007) directed the use of tobacco funds to create a "competitive statewide grant program allowing all Texas city and county health departments and local independent school districts to apply for funds." Approximately $1.3 million is available for FY 2008, and approximately $3.5 million will be available for renewal of funded contractors in FY 2009. The coalitions must conduct needs assessments regarding community tobacco use and tobacco-related health consequences, build capacity to address those needs, and plan, implement and evaluate evidence-based tobacco prevention and control strategies to address tobacco use among adults and youth. The

coalitions that were awarded grants through the RFP are: Lubbock Cooper Independent School District, Fort Bend County, Travis County, Bexar County, Northeast Texas Public Health District, and Ector/Midland County.

Behavioral Health Services for Veterans

Veterans and individuals returning from military service are increasingly putting pressure on the behavioral health system of the state. Many of these individuals and their families are caught in fragmented systems of service between the federal and state governments and private insurance. Increasingly, this group requires assistance in navigating the service delivery system. The problems these individuals and their families are experiencing will need to be addressed through collaborative work at the local, state, and national level.

DSHS Goal 3: Hospital Facilities and Services

DSHS will promote the recovery of persons with infectious disease, substance abuse and/or mental illness who require specialized treatment.

Goal 3 covers those direct services, mostly inpatient, that DSHS provides at state-administered facilities. These include mental health care provided at ten state hospitals, care for individuals with TB and other communicable diseases at the Texas Center for Infectious Disease (TCID), and primary health care at the South Texas Health Care System (STHCS).

State Mental Health Hospitals

Target Population

The State Mental Health Hospitals (SMHHs) admit individuals who have a mental illness and either present a substantial risk of serious harm to self or others or show a substantial risk of mental or physical deterioration. Special populations served include: children and adolescents, physically aggressive patients, persons with mental illness who are deaf, acute and sub-acute patients, persons with co-occurring psychiatric and substance abuse disorders, persons found not guilty by reason of insanity, and persons requiring competency restoration services.

The Waco Center for Youth admits only children from 10 to 17 years of age who are diagnosed as emotionally disturbed, who have a history of behavior adjustment problems, and who need a structured treatment program in a residential facility.

Service Description

The SMHH system includes nine state hospitals and the Waco Center for Youth. The primary role of the SMHH system is to provide inpatient services to persons with serious mental illnesses whose needs are not being met in a community setting.

State mental health hospitals provide specialized and intensive inpatient services. LMHAs jointly plan services in each hospital's service area with the SMHH. This system is shaped by local conditions and factors including the number of admissions and type of services to be provided. A seamless interaction of hospital-based and community-based services is promoted through coordination, collaboration, and communication.

South Texas Health Care System

Target Population

The STHCS provides outpatient care and services primarily to indigent adult residents throughout a four-county service area (Cameron, Hidalgo, Willacy, and Starr counties). The STHCS public health laboratory serves STHCS clinical needs and the public health needs of the Texas population for medical emergencies and bioterrorism responses. It is the only public facility south of San Antonio performing bioterrorism agent detection.

Service Description

STHCS is the outpatient primary health care component of Rio Grande State Center. STHCS provides services including:

- Outpatient primary care/internal medicine clinic;
- Patient drug assistance program;
- Cancer screening;
- Women's health (breast and cervical cancer control program; breast diagnostics and image studies; STD screening), diabetes, and endocrinology clinic;
- Diabetes education; and
- Diagnostic services.

A number of services are also provided through contracted providers including: adult outpatient TB services, consultations for surgery, and colonoscopy laboratory services (TB microbacteriology, Public Health STDs, immununohematology, and microbiology).

Texas Center for Infectious Disease

Target Population

TCID serves patients older than 16 years of age with a diagnosis of TB or Hansen's disease (leprosy) who require hospitalization or specialized services. These patients are referred by local health departments, private providers, and local courts managing patients with infectious TB and Hansen's disease, as well as referrals from other states with an interstate compact with Texas.

Service Description

TCID provides quality medical care for patients with TB, Hansen's disease, and other related infectious diseases. TCID provides inpatient services for patients requiring long lengths of stay to complete treatment. For surgical services, intensive care, sophisticated diagnostics, advanced therapeutics, and emergency care, TCID contracts with the University of Texas Health Science Center at Tyler, the University of Texas Health Science Center at San Antonio, and other San Antonio-area providers. The facility provides outpatient services to treat patients with TB and Hansen's disease, as well as complications and co-morbidities affecting treatment of those diseases.

Although many Texans think of TB as a disease of the past, it remains a communicable disease with the potential to spread and therefore must be contained. The importance of this effort is made even more serious by the development of drug-resistant and extremely drug-resistant strains. TCID has the capability to be used to respond to acts of bioterrorism and provide first line responders with expertise in communicable disease treatment.

DSHS Goal 3 Trends and Initiatives

Services Provided through State Mental Health Hospitals

The provision of specialty care for populations with specific needs has become an increasingly significant component of the service array in SMHHs. Statewide specialty services include:

- Maximum-security facility for adolescents and adults;
- Residential services for adolescents with serious psychiatric illness;
- Specialty services for persons with a mental illness who also have significant hearing impairment; and
- Criminal court commitments—for competency restoration and for persons found not guilty by reason of insanity.

State Mental Health Hospital Capacity

Since 2005, capacity of the SMHH system has been an issue, particularly in the area of forensic commitments for competency restoration. Patients in the SMHH system because of forensic commitment have doubled since 2001, and they represent at least 30 percent of patients in the system. In addition to the bed capacity added in 2006, DSHS has worked with the Legislature to contain pressure for more beds. Implementation of S.B. 867, 80th Legislature, Regular Session, 2007 is relieving pressure on maximum-security beds and will reduce the demand for inpatient competency restoration. S.B. 867 creates alternatives to inpatient restoration for certain defendants, and it expedites the judicial and administrative processes for persons already determined incompetent to stand trial. The waiting list for maximum-security beds has been significantly reduced. Implementation of the crisis redesign initiative will also reduce pressure on the state hospital system over time,

and DSHS has charged LMHAs with greater responsibility for helping to manage the balance of civil and forensic beds.

Crisis Stabilization Unit Pilot Project

H.B. 654, 80th Legislature, Regular Session, 2007 created a Crisis Stabilization Unit (CSU) pilot project to be housed on the Kerrville State Hospital grounds. Hill Country Community MHMR Center is designated to operate the 16-bed unit. The CSU will enhance access to appropriate services for patients needing psychiatric stabilization, and it will possibly avoid admissions to the state hospital or contacts with the court system. Implementation of this project is a collaborative effort involving HHSC, DSHS, and Hill Country Community MHMR Center.

Clinical Record System

Since 1998 SMHHs have been in the process of implementing an electronic medical record (EMR) system, with the goal of a completely electronic clinical record keeping system. Because of the need for reliable functioning, discussions are underway to improve the functionality at the user level. A system-wide effort has been launched to include end users in the process of identifying improvements that would make the system more user-friendly. DSHS, HHSC, and the system vendor are in the process of implementing suggestions from system users. The process will also include implementing two or more upgrades to the system, with the goal of having a user-friendly and high quality EMR.

Construction and Renovation of Health Care Facilities

Currently, DSHS is involved in a number of construction and renovation projects. In the 80th Legislative Session, DSHS received funding to: (1) construct a new facility in San Antonio for TCID, to replace the current facility, (2) construct a new facility in Harlingen to replace the current South Texas Health Care System facility, and (3) construct a new facility in Edinburg for primary care and substance abuse outpatient services. All of these projects are at various point of implementation, and DSHS will be working to complete these facilities this biennium.

The Legislature also appropriated bond authority to DSHS for various renovation projects at the SMHHs. The bonds were subject to voter approval, which occurred in November 2007. Most of renovations focus on projects that relate to the health and safety of patients and staff. These projects include critical Life Safety Code improvements, and roofing, air conditioning/ heating and electrical work. Projects are in the process of being initiated and will continue throughout the biennium. Because of the size and age of the DSHS facility campuses, repairs and renovations will be a perpetual need.

DSHS Goal 4: Consumer Protection Services

DSHS will achieve a maximum level of compliance by the regulated community to protect public health and safety.

Goal 4 programs protect the health of Texans by ensuring high standards in the following areas: health care facilities, health care-related professions (excluding physicians and nurses), EMS providers and personnel, food and food preparation, pharmaceuticals, medical and radiological devices, and consumer products.

Target Population

Regulatory services at DSHS oversee licensing for, enforcement if, and compliance with standards and regulations for health care facilities, credentialed professionals, and consumer safety products and services that affect the entire permanent and visiting population of Texas.

Service Description

The basic functions of regulatory services include:

- Developing and maintaining standards, within statutory authority, through stakeholder-inclusive rule development processes;
- Reviewing application materials and issuing licenses;
- Conducting quality assurance surveys, inspections, and complaint investigations; and
- Taking appropriate enforcement actions to promote compliance.

Currently, DSHS regulates approximately 190,000 individuals and 80,000 facilities/entities. In addition, there are a large number of entities that are not state-licensed, but over which DSHS holds some inspection and enforcement authority. Additionally, Regulatory Services includes two non-regulatory strategies: EMS/trauma systems and sexually violent predator management. Finally, within the strategies above, DSHS also has a disaster planning/homeland security role.

Health Care Professionals

Eleven independent licensing boards are administratively attached to DSHS. These boards regulate the practices of allied and mental health professions, and they adopt and enforce rules. DSHS provides the administrative support for their operations. These independent boards govern the following professions:

- Speech language pathologists and audiologists,
- Athletic trainers,
- Marriage and family therapists,
- Professional counselors,

- Social workers,
- Fitters and dispensers of hearing instruments,
- Sex offender treatment providers,
- Orthotists and prosthetists,
- Dietitians,
- Midwives, and
- Medical physicists.

DSHS governs 10 other licensing programs which include:

- Medical radiologic technologists,
- Respiratory care practitioners,
- Massage therapists,
- Perfusionists, and
- Chemical dependency counselors.

EMS, including firms, individuals, and education programs, also resides in this strategy.

The licensing process for Health Care Professionals (HCP) includes review of transcripts of educational courses/programs for appropriateness to each field of practice. A critical part of the eligibility requirement for most of the professions is the passing of a competency examination, developed either in-house or through a nationally recognized examination developed by a national test vendor. DSHS also performs criminal history background checks on applicants and license holders to ensure initial and continued eligibility, and the agency audits continuing education records to review the types of courses offered and to determine whether the licensees are in compliance. DSHS receives and investigates consumer complaints against the regulated professions and imposes disciplinary action against license holders when violations are substantiated.

Within the HCP strategy, DSHS also approves/certifies and monitors offender education programs and program instructors. The four mandated courses are Driving While Intoxicated (DWI) Education, DWI Intervention, Alcohol Education Program for Minors, and Drug Offender Education. Each program must utilize DSHS-approved curricula and offers administrator/instructor training in the delivery of the services. DSHS administers the training, approval, and monitoring of instructors for the Texas Youth Tobacco Awareness Program (TYTAP), to ensure that Texas youth are able to complete a tobacco awareness course. TYTAP implements the Texas Adolescent Tobacco Use and Cessation curriculum.

Health Care Facilities

DSHS regulates approximately 2,500 health care facilities including:

- Hospitals,
- Birthing centers,
- Ambulatory surgery centers,
- ESRD facilities,
- Special care facilities,
- Abortion facilities,
- Substance abuse facilities,
- Narcotic treatment facilities,
- CSU, and
- Private psychiatric hospitals.

DSHS is also a contractor for CMS, conducting compliance surveys for entities seeking certification as Medicare providers. In addition to including the state-licensed facilities listed above, this effort covers rural health clinics, portable x-ray services, outpatient physical therapy, and comprehensive outpatient rehabilitation facilities. DSHS is also a CMS contractor for the Clinical Laboratory Improvements Amendments program, which regulates all laboratory testing (except research) performed on humans.

Food (Meat) and Drug Safety

Food and drug products are regulated to prevent the sale and distribution of contaminated, adulterated, and mislabeled foods and drugs. This includes retail food establishments, food and drug manufacturers, wholesale food and drug distributors, food and drug salvagers, meat and poultry processors and slaughterers, milk and dairy food processors, and molluscan shellfish processors and shippers. Additionally, DSHS tests tissue samples from fish, monitors seafood harvesting areas, and certifies Texas bay waters for safety. State regulations and standards are closely tied to those of the U.S. Food and Drug Administration (FDA) and USDA, to ensure food products are safe and can be sold outside the borders of Texas. Drugs, cosmetics, and medical device manufacturers, distributors, and salvagers are also regulated for consumer health and safety.

Environmental Health

Regulation includes the licensing, inspection, and monitoring of asbestos, lead, and mold abatement activities; hazardous chemicals registration; and indoor air quality related activities. Hazardous consumer products such as bedding, toys, and playground equipment are regulated to keep Texans safe. Also critical to consumer health and safety are general sanitation services, such as inspections and regulation of school cafeterias, public swimming pools, day care centers, youth camps, tattoo

and body piercing studios, tanning studios, and retailers who sell products containing ephedrine or pseudoephedrine.

Radiation Control

DSHS protects Texans from the harmful effects of radiation by regulating the possession and use of radioactive materials (including nuclear medicine, industrial radiography, and oil and gas well logging) in a manner that maintains compatibility with the requirements of the 1963 Agreement between Texas and the U.S. Nuclear Regulatory Commission (U.S. NRC). DSHS also regulates radiation-producing machines such as x-ray, mammography, and laser. Additionally, this program develops radiological emergency response plans and conducts full scale exercises on those plans. The Texas Radiation Advisory Board is an eighteen-member, Governor-appointed board that provides advice on radiation rules and state radiation control policy.

EMS/Trauma Systems

DSHS is charged with developing, implementing, and evaluating a statewide EMS and trauma care system, including the designation of trauma facilities. The Governor's EMS and Trauma Advisory Council advises DSHS on rules and standards for the system.

Sexually Violent Predators

The Health and Safety Code provides a civil commitment procedure for the long-term supervision and treatment of sexually violent predators. The Council on Sex Offender Treatment, which is administratively attached to DSHS, is responsible for providing appropriate treatment, supervision, transportation, housing, and monitoring of individuals committed to this program after their release from prison.

DSHS Goal 4 Trends and Initiatives

Future Demand for Regulatory Services

As the population increases and new technologies develop, more entities and individuals will be subject to regulatory services. New realities all combine to add urgency to consumer protection services: emerging food-borne pathogens, vector-imported diseases such as West Nile Virus, and the necessity of increased security oversight of hazardous materials. The department currently uses risk-based compliance monitoring to ensure that the most critical needs are met, and the very nature of the growing demand will require additional staff expertise and other capacities. Evolving technologies and developing consumer demands may also result in initiatives that address the need to regulate new or additional allied health care professions and facilities.

Security of Radioactive Materials

New requirements to assure the security of radioactive materials will require additional staff to perform pre-license inspections and to perform increased security inspections. Due to elevated concerns of terrorists' attempts to obtain radioactive material for use in dirty bombs, the U.S. NRC is requiring the Radiation Control Program to implement procedures such as pre-licensing site visits and/or hand-delivery of licenses, so applications for the use of radioactive material are scrutinized more carefully, to ensure that the applicants are legitimate and the radioactive material will be used as intended. In a similar effort, the Radiation Control Program is partnering with U.S. DHS to ensure that radioactive material being brought into Texas ports or across Texas borders is destined for companies who are appropriately licensed to receive the material. Both of these efforts will likely increase program resource requirements.

Regulatory Automation System

Retrofitting the Regulatory Automation System (RAS) continues to be a challenge. Contractors originally developed the RAS for licensing programs only. To meet the needs of a comprehensive regulatory system involving licensing, inspections, and enforcement, the division recently received funding to complete the incorporation of the last regulatory programs into RAS, and to revise the system as much as possible to incorporate the additional needs. Full implementation will require upgrades to the system as they become available, to reduce data entry time and to realize other efficiencies.

DSHS Internal Assessment

DSHS is a complex agency that is responsible for carrying out essential functions required to improve the health and well-being of Texans. With nearly 12,000 employees, and oversight of 5,400 contractors, the agency is able to conduct activities and implement strategies necessary to meet federal and state policy mandates. DSHS-operated programs are located in 157 sites across the state. DSHS programs are managed within six distinct areas listed below. These DSHS service areas work together to achieve the agency's vision of *A Healthy Texas*.

Family & Community Health—Responsible for improving the health and well-being of Texas children, women, families, and individuals.

Mental Health & Substance Abuse—Responsible for improving the health and well-being of Texans across the life-span through substance abuse prevention, mental health promotion, and behavioral health treatment to persons with mental illness or substance abuse issues.

Prevention & Preparedness—Responsible for improving health and well-being in Texas by implementing programs that protect, promote, and improve the public's health by decreasing health threats and sources of disease.

Regional & Local Health—Responsible for improving health and well-being in Texas by addressing the needs of Local Public Health Agencies, DSHS Health Service Regions, and local communities.

Regulatory—Responsible for improving health and well-being in Texas by protecting the public's health and safety. This is accomplished by achieving a maximum level of compliance from the regulated community.

Chief Operating Officer—Responsible for improving the health and well-being of Texas by administering programs to manage the state's vital records and by collecting, analyzing, and publishing health data and information.

In addition to the internal agency service areas, DSHS has extensive involvement with external constituents. DSHS and its partners work together to:

- Monitor the health/behavioral health status of Texans to identify community or statewide health problems;
- Diagnose and investigate health problems and health hazards across the state;
- Inform, educate, and empower Texans regarding health/ behavioral health issues;
- Mobilize national, state, and local partnerships to identify and solve health/behavioral health problems;
- Develop policies and plans that support individual, community, and state health/ behavioral health efforts;
- Enforce laws and regulations that protect the health and ensure the safety of Texans;
- Link people across the state to necessary personal health/behavioral health services;
- Ensure a competent public/behavioral health workforce in Texas;
- Evaluate the effectiveness, accessibility, and quality of individual and population-based health/behavioral health services; and
- Participate in national, state, or local research to identify new insights and innovative solutions to health/behavioral health problems.

DSHS Internal Strengths and Challenges

Strengths

Existing internal DSHS strengths that serve as the foundation for future initiatives include:

- A dedicated staff of professionals committed to improving health and well-being in Texas;
- Readiness, including both experience and important assets such as the public health laboratory, to respond to natural or man-made disasters or biological threats;
- Participation in numerous state, national, and international efforts to address various public health, mental health, or substance abuse issues that impact Texans of all ages;
- Effective partnerships with stakeholders such as: policy-makers; external public health, mental health, and substance abuse organizations; advocates; and consumers of services;
- Established processes for communication among and between DSHS and key constituents;
- Performance-based contracts designed to monitor results and ensure accountability of service providers;
- An understanding of the unique public health and behavioral health needs of residents living on the Texas-Mexico border;
- Awareness of the changing demographics of the state and the resulting impact on the agency, its services, recipients of DSHS-funded services, and on the public health/behavioral health workforce; and
- Established relationships with Texas academic institutions, health science centers, and research entities.

Challenges

Given the breadth and scope of agency responsibilities, DSHS faces the following internal challenges:

- Recruitment and retention of staff;
- Continuous, timely communication between headquarters and the agencies' 157 locations across Texas;
- Coordination of business processes;
- Program development activities across service areas and administrative departments; and
- Employee morale, staff turnover, and development of a unified organizational culture.

Chapter X

Goals, Objectives, and Strategies

Health and Human Services Commission

The following presentation of goals, objectives, and strategies, by agency, reflects the negotiated structure approved by the Legislative Budget Board (LBB) and the Governor's Office of Budget, Planning, and Policy (GOBPP). This structure will later incorporate performance measures and become the framework for the agency's budget.

Goal 1: HHS Enterprise Oversight and Policy

HHSC will improve the effectiveness and efficiency of the delivery of health and human services in Texas through the oversight and coordination of a prompt, accurate, and comprehensive service delivery system.

Objective 1-1. Enterprise Oversight and Policy. By 2009, HHSC will improve the business operations of the Health and Human Services System to maximize federal funds, improve efficiency in system operations, improve accountability and coordination throughout the System, and ensure the timely and accurate provision of eligibility determination services for all individuals in need of Health and Human Services System programs.

Strategy 1-1-1. Enterprise Oversight and Policy. Provide leadership and direction to achieve an efficient and effective health and human services system.

Strategy 1-1-2. Integrated Eligibility and Enrollment. Provide accurate and timely eligibility and issuance services for financial assistance, medical benefits, and food stamps.

Objective 1-2. HHS Consolidated System Support Services. By 2009, HHSC will improve the operations of the Health and Human Services

System through the coordination and consolidation of administrative services.

Strategy 1-2-1. Consolidated System Support. Improve the operations of health and human service agencies through coordinated efficiencies in business support functions.

Strategy 1-2-2. HHS Transportation. Provide funding to other HHS agencies providing transportation services and assistance to clients.

Goal 2: Medicaid

HHSC will administer the state Medicaid system efficiently and effectively, using a comprehensive approach to integrate Medicaid client health services with other direct service delivery programs.

Objective 2-1. Medicaid Health Services. By 2009, HHSC will administer programs that provide medically necessary health care in the most appropriate, accessible, and cost-effective setting.

Strategy 2-1-1. Medicare and SSI. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to Medicaid-aged and Medicare-related persons, and Medicaid disabled and blind persons.

Strategy 2-1-2. TANF Adults and Children. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting for TANF-eligible adults and children.

Strategy 2-1-3. Pregnant Women. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting for Medicaid-eligible pregnant women.

Strategy 2-1-4. Children and Medically Needy. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to newborn infants and Medicaid-eligible children above the Temporary Assistance for Needy Families (TANF) income eligibility criteria, and medically needy persons.

Strategy 2-1-5. Medicare Payments. Provide accessible premium-based health services to certain Title XVIII Medicare eligible recipients.

Strategy 2-1-6. STAR+PLUS (Integrated Managed Care). Promote the development of integrated managed care systems for aged and disabled clients.

Objective 2-2. Other Medicaid Services. By 2009, HHSC will provide policy direction and management of the state's Medicaid program and maximize federal dollars.

Strategy 2-2-1. Cost Reimbursed Services. Provide medically necessary health care to Medicaid eligible recipients for services not covered under the insured arrangement including: federally qualified

health centers, undocumented persons, school health, and related services.

Strategy 2-2-2. Medicaid Vendor Drug. Provide prescription medication to Medicaid-eligible recipients as prescribed by their treating physician.

Strategy 2-2-3. Medicare Federal Give Back Provision. Provide the federal government with a phased-down state contribution as required by Sec. 103 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 related to the federal assumption of the cost of prescription drugs for full-benefit dual eligible Medicare and Medicaid clients.

Strategy 2-2-4. Medical Transportation. Support and reimburse for non-emergency transportation assistance to individuals receiving medical assistance.

Strategy 2-2-5. Medicaid Family Planning. Increase family planning services throughout Texas for adolescents and women.

Strategy 2-2-6. Upper Payment Limit. Provide supplemental Medicaid reimbursement to children hospitals for inpatient and outpatient services.

Objective 2-3. Special Services for Children. By 2009, HHSC will address the specific health and dental needs of children in Texas before associated problems become chronic and irreversible.

Strategy 2-3-1. Health Steps (EPSDT) Medical. Provide access to comprehensive diagnostic/treatment services for eligible clients by maximizing the use of primary prevention, early detection, and management of health care in accordance with all federal mandates.

Strategy 2-3-2. Health Steps (EPSDT) Dental. Provide dental care in accordance with all federal mandates.

Strategy 2-3-3. Health Steps (EPSDT) Comprehensive Care. Provide all medically necessary and federally allowable Medicaid services for conditions identified through an EPSDT screen or other health care encounter but not covered or provided under the State Medicaid Plan.

Objective 2-4. Medicaid Support. By 2009, HHSC will improve the quality of services by serving as the single state Medicaid agency.

Strategy 2-4-1. State Medicaid Office. Set the overall policy direction of the state Medicaid program and manage interagency initiatives to maximize federal dollars.

Goal 3: CHIP Services

HHSC will ensure health insurance coverage for eligible children in Texas.

Objective 3-1. CHIP Services. By 2009, HHSC will ensure health insurance coverage for eligible children in Texas.

Strategy 3-1-1. CHIP. Provide health care to uninsured children who apply for insurance through CHIP.

Strategy 3-1-2. Immigrant Children Health Insurance. Provide health care to certain uninsured, legal immigrant children who apply for insurance through CHIP.

Strategy 3-1-3. School Employee CHIP. Provide health care to children of certain school employees who apply for insurance through CHIP.

Strategy 3-1-4. CHIP Perinatal Services. Provide health care to perinates whose mothers apply for insurance through CHIP.

Strategy 3-1-5. CHIP Vendor Drug. Provide prescription medication to CHIP-eligible recipients (includes Immigrant Health Insurance and School Employee Children Insurance), as provided by their treating physician.

Goal 4: Encourage Self-Sufficiency

HHSC will encourage and promote self-sufficiency, safety, and long-term independence for families.

Objective 4-1. Assistance Services. By 2009, HHSC will provide appropriate support services that address the employment, financial, and/or nutritional needs of eligible persons.

Strategy 4-1-1. TANF Grants. Provide TANF grants to low-income Texans.

Strategy 4-1-2. Refugee Assistance. Assist refugees in attaining self-sufficiency through financial, medical, and social services, and disseminate information to interested individuals.

Strategy 4-1-3. Disaster Assistance. Provide financial assistance to victims of Presidentially-declared natural disasters.

Objective 4-2. Other Support Services. By 2009, HHSC will promote safety, self-sufficiency, and long-term independence for those living with domestic violence or other adverse circumstances.

Strategy 4-2-1. Family Violence Services. Provide emergency shelter and support services to victims of family violence and their

children, educate the public, and provide training and prevention support to institutions and agencies.

Strategy 4-2-2. Alternatives to Abortion. Provide pregnancy support services that promote childbirth for women seeking alternatives to abortion.

Strategy 4-2-3. Healthy Marriages. Support community-based initiatives providing marriage and relationship skills education to parents and new couples.

Goal 5: Program Support

Objective 5-1. Program Support.

Strategy 5-1-1. Central Program Support.

Strategy 5-1-2. IT Program Support.

Strategy 5-1-3. Other Support Services.

Strategy 5-1-4. Regional Program Support.

Goal 6: Information Technology Projects

Objective 6-1. Information Technology Projects.

Strategy 6-1-1. TIERS.

Goal 7: Office of Inspector General

Objective 7-1. Integrity and Accountability. By 2011, HHSC will improve health and human services programs and operations by protecting them against fraud, waste, and abuse.

Strategy 7-1-1. Office of Inspector General. Investigate fraud, waste, and abuse in the provision of all health and human services, enforce state law relating to the provision of those services, and provide utilization assessment and review of both clients and providers.

Department of Aging and Disability Services

Goal 1: Long-Term Services and Supports

To enable older and disabled Texans to live dignified, independent, and productive lives in a safe living environment through an accessible, locally-based, comprehensive and coordinated continuum of services and opportunities, to provide appropriate services and supports based on individual needs ranging from in-home and community based services for elderly people and people with disabilities who request assistance in maintaining their independence and increasing their quality of life, to institutional services for those who require that level of support, seeking to ensure health and safety and to maintain maximum independence for the client while providing the services and supports required.

Objective 1-1. Intake, Access, and Eligibility. Activities delivered by local entities and/or the state to promote eligibility determination and access to appropriate services and supports and the monitoring of those services and supports.

Strategy 1-1-1. Intake, Access, and Eligibility to Services and Supports. Provide functional eligibility determination, development of individual service plans based on client needs and preferences, assistance in obtaining information, and authorization of appropriate services and supports through the effective and efficient management of DADS staff and contracts with the Area Agencies on Aging (AAAs) and local Mental Retardation Authorities (MRAs).

Strategy 1-1-2. Guardianship. Provide full or limited authority over an incapacitated elderly or disabled adult who is the victim of validated abuse, neglect exploitation in a non-institutional setting or of an incapacitated minor in CPS conservatorship, as directed by the court, including such responsibilities as managing estates, making medical decisions and arranging placement and care.

Objective 1-2. Community Services and Supports—Entitlement. Provide Medicaid covered supports and services in homes and community settings which will enable elderly persons, persons with disabilities, and others who qualify for nursing facility care but can be served at home or in the community to maintain their independence and prevent institutionalization.

Strategy 1-2-1. Primary Home Care. Primary Home Care (PHC) is a Medicaid-reimbursed, non-technical, medically related personal services and supports services prescribed by a physician, available to

eligible clients whose health problems cause them to be limited in performing activities of daily living.

Strategy 1-2-2. Community Attendant Services. Medicaid-reimbursed subgroup of PHC in-eligible's that must meet financial eligibility of total gross monthly income of less than that equal to 300% of the SSI federal benefit rate.

Strategy 1-2-3. Day Activity and Health Services. DAHS provide daytime service five days a week (Mon-Fri) to individuals residing in the community in order to provide an alternative to placement in nursing facilities or other institutions.

Objective 1-3. Community Services and Supports—Waivers. Provide supports and services through Medicaid waivers in homes and community settings which will enable elderly persons, persons with disabilities and others who qualify for nursing facility care but can be served at home or in the community to maintain their independence and prevent institutionalization.

Strategy 1-3-1. Community Based Alternatives (CBA). CBA program is a Medicaid (Title XIX) Home and Community-based services waiver and provides services to aged and disabled adults as a cost-effective alternative to institutionalization.

Strategy 1-3-2. Home and Community Based Services (HCS). The Home and Community Based waiver program under Section 1915 (c) of Title XIX of the Social Security Act provides individualized services to consumers living in their family's home, their own homes, or other settings in the community as an alternative to residing in and ICF/MR.

Strategy 1-3-3. Community Living Assistance and Support Services (CLASS). Provides home and community-based services to individuals with diagnosis of related conditions qualifying them for placement in an Intermediate Care Facility for persons who have a disability, other than mental retardation originating before age 22.

Strategy 1-3-4. Deaf-Blind Multiple Disabilities (DBMD). Provides home and community-based services to adult individuals diagnosed with deaf, blind, and multiple disabilities as an alternative to residing in and ICF/MR.

Strategy 1-3-5. Medically Dependent Children Program (MDCP). Provides home and community-based services to clients under 21 years of age as an alternative to residing in a nursing facility. Services include respite, adjunct supports, adaptive aids, and minor home modification.

Strategy 1-3-6. Consolidated Waiver Program. This pilot 1915c waiver consolidates CBA, MDCP, CLASS, HCS, and DBMD waivers. Community Services and Supports case managers develop individualized service plans based on the participant's needs.

Strategy 1-3-7. Texas Home Living Waiver. The Texas Home and Living waiver program under Section 1915 (c) of Title XIX of the Social Security Act provide individualized services not to exceed $13,000 per year to consumers living in their family's home, their own homes, or other settings in the community.

Strategy 1-3-8. Other Waivers. Provide waiver services to eligible populations as approved by the appropriate federal agency.

Objective 1-4. Community Services and Supports—Non-Medicaid. Provide non-Medicaid services and supports in homes and community settings which will enable elderly persons, persons with disabilities and others who qualify for nursing facility care but can be served at home or in the community to maintain their independence and prevent institutionalization.

Strategy 1-4-1. Non-Medicaid Services. Provide a wide range of home and community-based social and supportive services to elderly and disabled persons who are not eligible for Medicaid that will assist these individuals to live independently, including family care, adult foster care, day activity and health services (XX), emergency response, personal attendant services, home delivered and congregate meals, homemaker assistance, chore maintenance, personal assistance, transportation, residential repair, health maintenance, health screening, instruction and training, respite, hospice and senior center operations.

Strategy 1-4-2. Mental Retardation Community Services. Provide services, other than those provided through the Medicaid waiver programs, to persons with mental retardation who reside in the community including independent living, employment services, day training, therapies, and respite services as well as community residential services that include an array of 24-hour residential arrangements for persons who do not live independently or with their families.

Strategy 1-4-3. Promoting Independence Plan. Provide public information, outreach, and awareness activities to individuals and groups who are involved in long term care relocation decisions, care assessments and intense case management of nursing facility residents that choose to transition to community-based care.

Strategy 1-4-4. In-Home and Family Support. Provide cash subsidy and provide reimbursement for capital improvements, purchase of equipment, and other expenses to enable elderly persons and persons with disabilities to maintain their independence and prevent institutionalization.

Strategy 1-4-5. MR In-Home Services. The mental retardation portion of the In-Home and Family Support (IHFS) program. Provides financial assistance to adults or children with a mental disability or to

their family for the purpose of purchasing items that are above and beyond the scope of usual needs, that are necessitated by the person's disability and that directly support that person to live in his/her natural home.

Objective 1-5. Program of All-inclusive Care for the Elderly (PACE). Promote the development of integrated managed care systems for aged and disabled individuals.

Strategy 1-5-1. Program of All-inclusive Care for the Elderly (PACE). The PACE program provides community-based services to frail and elderly people who qualify for nursing facility placement. Services may include in-patient and outpatient medical care at a capitated rate.

Objective 1-6. Nursing Facility and Hospice Payments. Provide payments which will promote quality of care for individuals with medical problems that require nursing facility or hospice care.

Strategy 1-6-1. Nursing Facility and Hospice Payments. The nursing facility program offers institutional nursing and rehabilitation care to Medicaid-eligible recipients who demonstrate a medical condition requiring the skills of a licensed nurse on a regular basis.

Strategy 1-6-2. Medicare Skilled Nursing Facility. Provide co-insure payments for Medicaid recipients residing in Medicare (XVIII) skilled nursing facilities, for Medicaid/Qualified Medicare Beneficiary (QMB) recipients and for Medicare only QMB recipients.

Strategy 1-6-3. Hospice. Provide short term palliative care in the home or in community settings, long-term care facilities or in hospital settings to terminally ill Medicaid individuals for whom curative treatment is no longer desired and who have a physician's prognosis of six months or less to live.

Strategy 1-6-4. Promoting Independence Services. Provide community-based services that enable nursing facility clients to relocate from nursing facilities back into community settings.

Objective 1-7. Intermediate Care Facilities—Mental Retardation. Provide residential services and supports for persons with mental retardation living in intermediate care facilities (ICFs/MR).

Strategy 1-7-1. Intermediate Care Facilities - Mental Retardation (ICF/MR). The Intermediate Care Facilities for Mental Retardation (ICF/MR) are residential facilities of four or more beds providing 24-hour care. Funding for ICF/MR services is authorized through Title XIX of the Social Security Act (Medicaid) and includes both the federal portion and state required match.

Objective 1-8. MR State Schools Services. Provide specialized assessment, treatment, support and medical services in state school and state center programs for persons with mental retardation.

Strategy 1-8-1. MR State Schools Services. Provides direct services and support to persons living in state schools. State schools provide 24-hour residential services for persons with mental retardation who are medically fragile or severely physically impaired or have severe behavior problems and who choose these services or cannot currently be served in the community.

Objective 1-9. Capital Repairs and Renovations. Efficiently manage and improve the assets and infrastructure of state facilities.

Strategy 1-9-1. Capital Repairs and Renovations. Provides funding for the construction and renovation of facilities at the state schools. The vast majority of projects are to bring existing facilities into compliance with the requirements in the Life Safety Code and/or other critical repairs and renovations, including fire sprinkler systems, fire alarm systems, emergency generators, fire/smoke walls, roofing, air conditioning, heating, electrical, plumbing, etc.

Goal 2: Regulation, Certification, and Outreach

Provide licensing, certification and contract enrollment services, as well as financial monitoring and complaint investigation, to ensure that residential facilities, home and community support services agencies, and individuals providing services in facilities or home settings comply with state and federal standards and that individuals receive high-quality services and are protected from abuse, neglect, and exploitation.

Objective 2-1. Regulation, Certification, and Outreach. Provide licensing, certification and contract enrollment services, as well as financial monitoring and complaint investigation, to ensure that residential facilities, home and community support services agencies, and individuals providing services in facilities or home settings comply with state and federal standards and that individuals receive high-quality services and are protected from abuse, neglect, and exploitation.

Strategy 2-1-1. Facility and Community-Based Regulation. Provide licensing, certification, contract enrollment services, financial monitoring and complaint investigation to ensure that residential facilities and home and community support services agencies comply with state and federal standards and individuals receive high-quality services.

Strategy 2-1-2. Credentialing/Certification. Provide credentialing, training and enforcement services to qualify individuals to provide

services to long-term care facility and home health care agency individuals in compliance with applicable law and regulations.

Strategy 2-1-3. Quality Outreach. Provide quality monitoring and rapid response team visits in order to assess quality and promote quality improvement in nursing facilities.

Goal 3: Indirect Administration

Assure the efficient, quality, and effective administration of services provided to elderly persons and persons with disabilities.

Objective 3-1. General Program Support.

Strategy 3-1-1. Central Administration. Supports administrative functions for all DADS programs including executive direction and leadership, legal, civil rights, hearings of provider appeals, planning, budget management, fiscal accounting and reporting, asset management, program statistics, public information, state and federal government relations, internal audit, and program support.

Strategy 3-1-2. Information Technology Program Support. Provides technology products, services, and support to all DADS divisions to further their efforts in achieving the DADS Mission. Services include application development and support, desktop and LAN support and troubleshooting, coordination of cabling and hardware repair, and liaison with external automation services providers.

Strategy 3-1-3. Other Support Services. Includes statewide policy and oversight of support services including contract management policy, historically underutilized businesses, forms and handbook management, records management and storage, building maintenance, mailroom, and inventory.

Strategy 3-1-4. Regional Administration. Supports administrative functions for all DADS programs out in the Regions across the state.

Department of Assistive and Rehabilitative Services

Goal 1: Children with Disabilities

DARS will ensure that families with children with disabilities receive quality services enabling their children to reach their developmental goals.

Objective 1-1. ECI Awareness and Services. To ensure that by the end of fiscal year 2009, 100 percent of eligible children and their families have access to the quality early intervention services resources and supports they need to reach their developmental goals as outlined in the Individual Family Service Plan.

Strategy 1-1-1. ECI Services. Conduct statewide activities which ensure that eligible infants, toddlers and their families are identified and families have access to information about the importance of early intervention and how to receive the resources and support they need to reach their service plan goals. Provide eligibility determination services to all referred children and determine eligibility for comprehensive and follow along services. Administer a statewide comprehensive system of services to ensure that eligible infants, toddlers and their families have access to the resources and support they need to reach their service plan goals.

Strategy 1-1-2. ECI Respite Services. Ensure that resources are identified and coordinated to provide respite service to help preserve the family unit and prevent costly out-of-home placements.

Strategy 1-1-3. Ensure Quality ECI Services. Ensure the quality of early intervention services by offering training and technical assistance, establishing service and personnel standards, and evaluating consumer satisfaction and program performance.

Objective 1-2. Services for Blind Children. Ensure 90 percent of eligible blind and visually impaired children and their families will receive blind children's vocational discovery and development services as developed in their individual service plans by the end of fiscal year 2009.

Strategy 1-2-1. Habilitative Services for Children. Provide information and training for blind and visually impaired children and their families so these children have the skills and confidence to live as independently as possible.

Strategy 1-3-1. Autism Program. Pilot autism services for children 3-8.

Goal 2: Persons with Disabilities

DARS will provide persons with disabilities quality services leading to employment and living independently.

Objective 2-1. Rehabilitation Services—Blind. To provide by the end of FY 2009, quality rehabilitation services for eligible persons who are blind or visually impaired and subsequently place in employment 68.9 percent of those persons that received planned vocational rehabilitation services consistent with informed consumer choice and abilities. Additionally, to provide quality consumer-directed independent living services for eligible persons who are blind or visually impaired.

Strategy 2-1-1. Independent Living Services—Blind. Provide quality, consumer-directed independent living services that focus on acquiring skills and confidence to live as independently as possible in the community for eligible persons who are blind or visually impaired.

Strategy 2-1-2. Blindness Education. Provide screening, education, and urgently needed eye-medical treatment to prevent blindness.

Strategy 2-1-3. Vocational Rehabilitation—Blind. Rehabilitate and place persons who are blind or visually impaired in competitive employment or other appropriate settings, consistent with informed choice and abilities.

Strategy 2-1-4. Business Enterprises of Texas. Provide employment opportunities in the food service industry for persons who are blind or visually impaired.

Strategy 2-1-5. Business Enterprises of Texas Trust Fund. Administer trust funds for retirement and benefits program for individuals licensed to operate vending machines under Business Enterprises of Texas (estimated and nontransferable).

Objective 2-2. Deaf and Hard of Hearing Services. To increase the number of persons (who are deaf or hard hearing) receiving quality services by 10 percent by the end of fiscal year 2009.

Strategy 2-2-1. Contract Services—Deaf. Develop and implement a statewide program to ensure continuity of services to persons who are deaf or hard of hearing. Ensure more effective coordination and cooperation among public and nonprofit organizations providing social and educational services to individuals who are deaf or hard of hearing.

Strategy 2-2-2. Education, Training, and Certification—Deaf. Facilitate communication access activities through training and educational programs to enable individuals who are deaf or hard of hearing to attain equal opportunities to participate in society to their potential and reduce their isolation regardless of location, socioeconomic status, or degree of disability. To test interpreters for

the deaf and hard of hearing to determine skill level and certify accordingly, and to regulate interpreters to ensure adherence to interpreter ethics.

Strategy 2-2-3. Telephone Access Assistance. Ensure equal access to the telephone system for persons with a disability (estimated and nontransferable).

Objective 2-3. General Disabilities Services. To provide by the end of FY 2009, quality vocational rehabilitation services to eligible persons with general disabilities and subsequently place in employment 55.8 percent of those persons that received planned vocational rehabilitation services consistent with informed consumer choice and abilities. Additionally, to provide quality consumer-directed independent living services to persons with significant disabilities who have been determined eligible.

Strategy 2-3-1. Vocational Rehabilitation—General. Rehabilitate and place people with general disabilities in competitive employment or other appropriate settings, consistent with informed consumer choice and abilities.

Strategy 2-3-2. Independent Living Centers. Work with independent living centers and the State Independent Living Council (SILC) to establish the centers as financially and programmatically independent from the Department of Assistive and Rehabilitative Services and financially and programmatically accountable for achieving independent living outcomes with their clients.

Strategy 2-3-3. Independent Living Services—General. Provide consumer-driven and DARS counselor-supported independent living services to people with significant disabilities statewide.

Strategy 2-3-4. Comprehensive Rehabilitation. Provide consumer-driven and counselor-supported Comprehensive Rehabilitation Services for people with traumatic brain injuries or spinal cord injuries.

Goal 3: Disability Determination

DARS will enhance service to persons with disabilities by achieving accuracy and timeliness within the Social Security Administration Disability Program guidelines and improving the cost-effectiveness of the decision making process in the disability determination services.

Objective 3-1. Accuracy of Determination. To achieve annually through 2009 the decisional accuracy of 90.6 percent and timeliness of 125 days as measured by Social Security Administration Disability Program guidelines.

Strategy 3-3-1. Disability Determination Services (DDS). Determine eligibility for federal Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits.

Goal 4: Program Support

Objective 4-1. Program Support.

Strategy 4-1-1. Central Program Support.

Strategy 4-1-2. Regional Program Support.

Strategy 4-1-3. Other Program Support.

Strategy 4-1-4. IT Program Support.

Department of Family and Protective Services

Goal 1: Statewide Intake Services

DFPS will ensure access to child and adult protective services, to child care regulatory services, and to information on services offered by DFPS programs.

Objective 1-1. Provide 24-hour Access to Services. Provide professionals and the public 24-hours 7 days per week, the ability to report abuse/neglect/exploitation and to access information on services offered by DFPS programs via phone, fax, email or the Internet.

Strategy 1-1-1. Statewide Intake Services. Provide a comprehensive system with automation support for receiving reports of persons suspected to be at risk of abuse/neglect/exploitation and assign for investigation those reports that meet Texas Family Code and Human Resource Code.

Goal 2: Child Protective Services

In collaboration with other public and private entities, protect children from abuse and neglect by providing an integrated service delivery system that results in quality outcomes.

Objective 2-1. Reduce Child Abuse/Neglect. Reduce Child Abuse/Neglect - By 2011, provide or manage a quality integrated service

delivery system for 70 percent of children at risk of abuse/neglect to mitigate the effects of maltreatment and assure that confirmed incidence of abuse/neglect does not exceed 7.3 per 1,000 children.

Strategy 2-1-1. CPS Direct Delivery Staff. Provide caseworkers and related staff to conduct investigations and deliver family-based safety services, out-of-home care, and permanency planning for children who are at risk of abuse/neglect and their families.

Strategy 2-1-2. CPS Program Support. Provide staff, training, automation, and special projects to support a comprehensive and consistent system for the delivery of child protective services.

Strategy 2-1-3. TWC Foster Day Care. Provide purchased day care services for foster children where both or one foster parent works full-time.

Strategy 2-1-4. TWC Relative Day Care. As part of the supportive services associated with the Relative and Other Designated Caregiver Program, provide purchased day care services for kinship caregivers who work full-time.

Strategy 2-1-5. TWC Protective Day Care. Provide purchased day care services for children living at home to control and reduce the risk of abuse or neglect and to provide stability while a family is working on changes to reduce the risk.

Strategy 2-1-6. Adoption Purchased Services. Provide purchased adoption services with private child-placing agencies to facilitate the success of service plans for children who are legally free for adoption including recruitment, screening, home study, placement, and support services.

Strategy 2-1-7. Post-Adoption Purchased Services. Provide purchased post-adoption services for families who adopt children in the conservatorship of DFPS including casework, support groups, parent training, therapeutic counseling, respite care, and residential therapeutic care.

Strategy 2-1-8. Preparation for Adult Living (PAL) Purchased Services. Preparation for Adult Living (PAL) Purchased Services. Provide purchased adult living services to help and support youth preparing for departure from DFPS substitute care including life skills training, money management, education/training vouchers, room and board assistance, and case management.

Strategy 2-1-9. Substance Abuse Purchased Services. Provide purchased residential chemical dependency treatment services for adolescents who are in the conservatorship of DFPS and/or families referred to treatment by DFPS.

Strategy 2-1-10. Other CPS Purchased Services. Provide purchased services to treat children who have been abused or neglected, to enhance the safety and well-being of children at risk of

abuse and neglect, and to enable families to provide safe and nurturing home environments for their children.

Strategy 2-1-11. Foster Care and Relative Monetary Assistance Payments. Provide financial reimbursement for the care, maintenance and support of children who have been removed from their homes and placed in licensed, verified childcare facilities; and monetary assistance for children in the relative and other designated caregiver program.

Strategy 2-1-12. Adoption Subsidy Payments. Provide grant benefit payments for families that adopt foster children with special needs who could not be placed in adoption without financial assistance, and one-time payments for non-recurring adoption costs.

Goal 3: Prevention and Early Intervention Services

DFPS will increase family and youth protective factors through the provision of contracted prevention and early intervention services for at-risk children, youth and families to prevent child abuse and neglect and juvenile delinquency.

Objective 3-1. To manage and support prevention and early intervention services for at-risk children, youth, and families through community based contracted providers.

Strategy 3-1-1. Services to At-Risk Youth (STAR) Program. Provide contracted prevention services for youth age 10-17 who are in at-risk situations, runaways, Class C delinquents, and for youth under the age of 10 who have committed delinquent acts.

Strategy 3-1-2. Community Youth Development (CYD) Program. Provide funding and technical assistance to support collaboration by community groups to alleviate family and community conditions that lead to juvenile crime.

Strategy 3-1-3. Texas Families Program. Provide community-based prevention services to alleviate stress and promote parental competencies and behaviors that will increase ability of families to successfully nurture their children.

Strategy 3-1-4. Child Abuse Prevention Grants. Provide child abuse prevention grants to develop programs, public awareness, and respite care through community-based organizations.

Strategy 3-1-5. Other At-Risk Prevention Programs. Provide funding for community-based prevention programs to alleviate conditions that lead to child abuse or neglect and juvenile crime.

Strategy 3-1-6. At-Risk Prevention Program Support. Provide program support for at-risk prevention services.

Goal 4: Adult Protective Services

collaboration with other public and private entities, protect the elderly and adults with disabilities from abuse, neglect, and exploitation by investigating in state operated and/or contracted MH and MR settings, and by providing an integrated service delivery system that results in quality outcomes, and reduce the incidence of abuse, neglect, and exploitation by maximizing resource.

Objective 4-1. Reduce Adult Maltreatment. By 2011, deliver protective services to 75 percent of vulnerable adults at risk of maltreatment so that abuse/neglect/exploitation does not exceed 9.5 per 1,000, and provide thorough and timely investigations of reports of maltreatment in mental health and mental retardation settings.

Strategy 4-1-1. APS Direct Delivery Staff. Provide caseworkers and related staff to conduct investigations and provide or arrange for services for vulnerable adults.

Strategy 4-1-2. APS Program Support. Provide staff, training, automation, and special projects to support a comprehensive and consistent system for the delivery of adult protective services.

Strategy 4-1-3. MH and MR Investigations. Provide a comprehensive and consistent system for the investigation of reports of abuse, neglect, and exploitation of persons receiving services in mental health and mental retardation settings.

Goal 5: Child Care Regulation

DFPS will achieve a maximum level of compliance by the regulated child care operations to protect the health, safety, and well being of children in out-of-home care.

Objective 5-1. Maintain Care Standards. By 2011, assure that occurrences where children are placed at serious risk in licensed day care facilities, licensed residential facilities, and registered family homes do not exceed 63.3 percent of all validated incidents.

Strategy 5-1-1. Child Care Regulations. Provide a comprehensive system of consultation, licensure, and regulation to ensure maintenance of minimum standards by day care and residential childcare facilities, registered family homes, child-placing agencies, facility administrator, and child placing agency administrators.

Goal 6: Indirect Administration

Objective 6-1. Indirect Administration. Provide for the efficient management and performance of agency administrative functions.

Strategy 6-1-1. Central Administration. Provide funding to efficiently manage and perform the centralized administrative functions of the agency.

Strategy 6-1-2. Other Support Services. Provide for State Office staff responsible for inventory coordination and records management activities.

Strategy 6-1-3. Regional Administration. Provide for field managers and their staff who provide functions such as business services and automation support at the regional level throughout the state.

Strategy 6-1-4. Information Technology Program Support. Information technology program support.

Strategy 6-1-5. Agency-wide Automated Systems (Capital Projects Only). Develop and enhance automated systems that serve multiple programs.

Department of State Health Services

Goal 1: Preparedness and Prevention Services

DSHS will protect and promote the public's health by decreasing health threats and sources of disease.

Objective 1-1. Improve health status through preparedness and information. To enhance state and local public health systems' resistance to health threats, preparedness for health emergencies, and capacities to reduce health status disparities; and to provide health information for state and local policy decisions.

Strategy 1-1-1. Public Health Preparedness and Coordinated Services. Plan and implement programs to ensure preparedness and rapid response to bioterrorism, natural epidemics, and other public health and environmental threats and emergencies. Coordinate essential public health services through public health regions and affiliated local health departments. Coordinate activities to improve health conditions on the Texas Mexico border and to reduce racial, ethnic, and geographic health disparities throughout Texas.

Strategy 1-1-2. Health Registries, Information, and Vital Records. Collect, analyze, and distribute information on health and health care, and operate birth defects, trauma, and cancer registries, poison control network and environmental investigations. Maintain a system for recording, certifying, and disseminating information on births, deaths, and other vital events in Texas.

Objective 1-2. Infectious disease control, prevention and treatment. To reduce the occurrence and control the spread of preventable infectious diseases.

Strategy 1-2-1. Immunize Children and Adults in Texas. Implement programs to immunize children and adults in Texas.

Strategy 1-2-2. HIV/STD Prevention. Implement programs of prevention and intervention including preventive education, case identification and counseling, HIV/STD medication, and linkage to health and social service providers.

Strategy 1-2-3. Infectious Disease Prevention, Epidemiology and Surveillance. Implement programs and develop measures to prevent, detect, track, investigate, control, or treat tuberculosis, hepatitis C, outbreaks of infectious diseases, and the spread of animal-borne diseases in humans. Administer the Refugee Health Screening Program.

Objective 1-3. Health Promotion, Chronic Disease Prevention, and Specialty Care. To use health promotion for reducing the occurrence of preventable chronic disease and injury, to administer abstinence education programs, and to administer service care programs related to certain chronic health conditions.

Strategy 1-3-1. Health Promotion and Chronic Disease Prevention. Develop and implement community interventions to reduce health risk behaviors that contribute to chronic disease and injury. Administer service programs for Alzheimer's disease.

Strategy 1-3-2. Abstinence Education. Increase abstinence education programs in Texas.

Strategy 1-3-3. Kidney Health Care. Administer service programs for kidney specialty care.

Strategy 1-3-4. Children with Special Health Care Needs. Administer service program for children with special health care needs.

Strategy 1-3-5. Epilepsy Hemophilia Services. Administer service programs for epilepsy and hemophilia.

Objective 1-4. Laboratory Operations. To operate a reference laboratory in support of public health program activities.

Strategy 1-4-1. Laboratory Services. Provide analytical laboratory services in support of public health program activities, Women's Health Services and the South Texas Health Care Center.

Goal 2: COMMUNITY HEALTH SERVICES

DSHS will improve the health of children, women, families, and individuals, and enhance the capacity of communities to deliver health care services.

Objective 2-1. Provide primary care and nutrition services. To develop and support primary health care and nutrition services to children, women, families, and other qualified individuals though community based providers.

Strategy 2-1-1. Provide WIC Services: Benefits, Nutrition Education & Counseling. Administer nutrition services, including benefits, for eligible low income women, infants, and children (WIC) clients, nutrition education, and counseling.

Strategy 2-1-2. Women and Children's Health Services. Provide easily accessible, quality and community-based maternal and child health services to low income women, infants, children, and adolescents.

Strategy 2-1-3. Family Planning Services. Provide family planning services for adolescents and women.

Strategy 2-1-4. Community Primary Care Services. Develop systems of primary and preventive health care delivery in underserved areas of Texas.

Objective 2-2. Provide behavioral health services. To support services for mental health and for substance abuse prevention, intervention, and treatment.

Strategy 2-2-1. Mental Health Services for Adults. Assure availability of and access to appropriate services in the community for adults with serious mental illness.

Strategy 2-2-2. Mental Health Services for Children. Provide supports and services for children with mental health needs and their families.

Strategy 2-2-3. Community Mental Health Crisis Services.

Strategy 2-2-4. NorthSTAR Behavioral Health Waiver. Provide mental health and substance abuse inpatient and outpatient services using a managed care model for adults and children.

Strategy 2-2-5. Substance Abuse Prevention, Intervention, and Treatment. Implement prevention and intervention services to reduce

the risk of substance use, abuse and dependency; to interrupt illegal substance use by youth and adults and reduce harmful use of legal substances by adults. Implement a continuum of community and family based treatment and related services for chemically dependent persons. Optimize performance quality and cost efficiency through the managing and monitoring of contracted services.

Strategy 2-2-5. Develop a Statewide Program to Reduce the Use of Tobacco Products. Develop and implement programs of education, prevention, and cessation in the use of tobacco products.

Objective 2-3. Community Capacity Building. To develop and enhance capacities for community clinical service providers and regionalized emergency health care systems.

Strategy 2-3-1. EMS and Trauma Care Systems. Develop and enhance regionalized emergency health care systems.

Strategy 2-3-2. FQHC Infrastructure Grants. Provide assistance to develop new and expand existing Federally Qualified Health Centers in Texas.

Strategy 2-3-3. Indigent Health Care Reimbursement (UTMB). Reimburse the provision of indigent health services through the deposit of funds in the State-owned Multicategorical Teaching Hospital Account.

Strategy 2-3-4. County Indigent Health Care Services. Provide support to local governments that provide indigent health care services.

Goal 3: Hospital Facilities and Services

DSHS will promote the recovery of persons with infectious disease and mental illness who require specialized treatment.

Objective 3-1. Provide state owned hospital services and facility operations. To provide for the care of persons with infectious disease or mental illness through state owned hospitals.

Strategy 3-1-1. Texas Center for Infectious Diseases. Provide for more than one level of care of tuberculosis, infectious diseases, and chronic respiratory diseases at Texas Center for Infectious Diseases.

Strategy 3-1-2. South Texas Health Care System. Provide for more than one level of care of tuberculosis and other services through South Texas Health Care System.

Strategy 3-1-3. Mental Health State Hospitals. Provide specialized assessment, treatment, and medical services in state mental health facility programs.

Objective 3-2. Provide private owned hospital services. To provide for the care of persons with mental illness through privately owned hospitals.

Strategy 3-2-1. Mental Health Community Hospitals. Provide inpatient treatment, crisis assessment, and medical services to adults and children served in community hospitals.

Goal 4: Consumer Protection Services

DSHS will achieve a maximum level of compliance by the regulated community to protect public health and safety.

Objective 4-1. Provide licensing and regulatory compliance. To ensure timely, accurate licensing, certification, and other registrations; to provide standards that uphold safety and consumer protection; and to ensure compliance with standards.

Strategy 4-1-1. Food (Meat) and Drug Safety. Design and implement programs to ensure the safety of food, drugs, and medical devices.

Strategy 4-1-2. Environmental Health. Design and implement risk assessment and risk management regulatory programs for consumer products, occupational and environmental health, and community sanitation.

Strategy 4-1-3. Radiation Control. Design and implement a risk assessment and risk management regulatory program for all sources of radiation.

Strategy 4-1-4. Health Care Professionals. Implement programs to issue licenses, certifications, and other registrations of health care professionals, and to ensure compliance with standards.

Strategy 4-1-5. Health Care Facilities. Implement programs to license/certify, monitor compliance, and provide technical assistance to health care facilities.

Strategy 4-1-6. Texas Online. Estimated and Nontransferable.

Strategy 4-1-7. Sex Offender Treatment and Supervision.

Goal 5: Indirect Administration

Objective 5-1. Indirect administration.

Strategy 5-1-1. Central Administration.

Strategy 5-1-2. Information Technology Program Support.

Strategy 5-1-3. Other Support Services.

Strategy 5-1-4. Regional Administration.

Goal 6: Capital Items

Objective 6-1. Manage capital projects.

Strategy 6-1-1. Laboratory (Austin) Bond Debt. Service bond debt on reference laboratory.

Strategy 6-1-2. Construction: Health Care Facilities. TCID. Construct and renovate state facilities for the delivery of care.

Strategy 6-1-3. Construction: Health Care Facilities. South Texas Health Care System: Harlingen. Construct and renovate state facilities for the delivery of care.

Strategy 6-1-4. Construction: Health Care Facilities, South Texas Health Care System: Hidalgo County/Edinburg.

Strategy 6-1-5. Capital Repair and Renovation: Mental Health Facilities. Conduct maintenance and construction projects critical to meeting accreditation/certification standards and to ensuring the safety of consumers.