



# **Health and Human Services System Strategic Plan 2011–15**

**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**

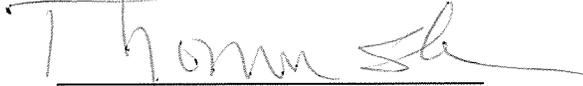
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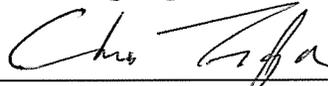
# Health and Human Services System Strategic Plan 2011–2015

## Health and Human Services Commission



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## Department of Aging and Disability Services



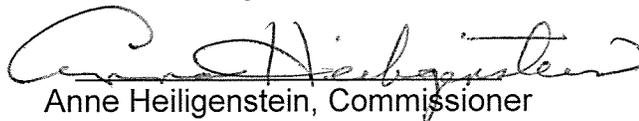
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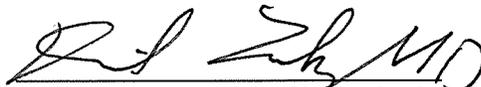
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**Submitted July 2, 2010**



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# Texas Health and Human Services System Strategic Plan for 2011-15

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# Executive Summary

This Health and Human Services System Strategic Plan for 2011-15 assesses the economic, demographic, and legislative environment in which the five state agencies within the Texas Health and Human Services (HHS) system will operate during the plan period. The plan focuses on current and planned actions the agencies are undertaking to address the major challenges associated with significant population growth, the recent recession, and increasing caseloads.

Development of this plan began with the recognition that Texas taxpayers and leadership expect state agencies to make the best possible use of available resources even under challenging conditions. Health and Human Services Commissioner Executive Commissioner Suehs, who was appointed by the Governor in August 2009, directed the development of a new system vision and a set of strategic priorities to guide the planning effort. The vision statement for the HHS system renews the focus on customer service and emphasizes quality, cost-effectiveness, and results—for improved health, safety, and greater independence of Texans. The strategic priorities direct activities and decision-making throughout the system to:

- Improve the health and well-being of Texans;
- Create opportunities for increased self-sufficiency and independence;
- Protect vulnerable Texans from abuse, neglect, and exploitation;
- Deliver the highest quality of customer service;
- Encourage partnership and community involvement; and
- Strengthen and support the health and human services workforce.

The plan identifies specific items of focus under each of the above priorities. For example, under the customer service priority, improving business processes to create a more coordinated, cost-effective, and customer friendly service delivery system is identified as one area of focus.

Chapter 1 of the plan presents the statewide vision, priority goals, and benchmarks developed by the Governor and the Legislative Budget Board (LBB). Chapter 2 lays out the HHS system vision and philosophy, which all HHS agencies adopted for this planning cycle. Chapter 3 describes the economic and legislative environment that will impact service delivery for the HHS system over the plan period. The individual agency sections in Chapters 4-8 discuss each agency's challenges and opportunities, cross-agency coordination and planning initiatives, and agency-

specific initiatives. Appendix F provides a description of target populations and services provided through agency programs.

The following challenges and opportunities and the actions planned to address the challenges are discussed in the individual agency chapters of this plan.

#### Health and Human Services Commission (HHSC)

- Ensuring Quality, Outcomes, and Cost-Effectiveness
- Managing Increasing Medicaid Costs
- Improving Eligibility Processes
- Evaluating Impact of Federal Health Care Reform
- Renewing the Focus on Customer Service and Community Involvement

#### Department of Aging and Disability Services (DADS)

- Ensuring the Health and Safety of Individuals Residing in State Supported Living Centers and Community Settings
- Meeting Increased Demand for Home and Community Based Services
- Improving Access to Long-Term Services and Supports
- Recruiting and Retaining Qualified Regulatory Staff
- Preparing for the Aging of the Texas Population

#### Department of Assistive and Rehabilitative Services (DARS)

- Evaluating the Early Childhood Intervention Program
- Managing Limited Services for Children with Autism
- Improving Direct Service Delivery Program Staffing
- Preparing for a Potential Change in the Federal Vocational Rehabilitation Funding Formula
- Expanding Vocational Rehabilitation Services to Rural Areas
- Strengthening the Statewide Network of Centers for Independent Living

#### Department of Family and Protective Services (DFPS)

- Improving Child Protective Services Capacity
- Ensuring Adult Protective Services as Safety Net
- Addressing Capacity Needs of Statewide Intake Services
- Setting Standards for Child Care Licensing
- Ensuring Due Process Rights

#### Department of State Health Services (DSHS)

- Addressing Public and Mental Health Needs

- Preventing Chronic Disease, Infectious Disease, and Substance Abuse
- Improving Response to Public Health Threats and Disasters
- Increasing Emphasis on Health Care Quality
- Improving Public Health Data Capacity
- Maintaining Regulatory Structure and Capacity

Following the individual agency chapters, Chapter 9 presents each agency's proposed goals, objectives, and strategies for the coming biennium. The final chapter contains the Information Resources Strategic Plan required by LBB instructions for preparing and submitting agency strategic plans for 2011-15.

## **Conclusion**

The HHS System Strategic Plan reveals an action plan for navigating significant internal and external challenges over the next several years. The plan describes a new framework to guide how HHS agencies and employees will do business, support customers, and involve local stakeholders and communities while remaining accountable to taxpayers, communities, and the public at large.



# Chapter 1

## Statewide Vision, Mission, and Philosophy

### 1.1 Introduction

Through the enactment of House Bill (H.B.) 2292, 78<sup>th</sup> Legislature, Regular Session, 2003, the Governor and Legislature directed the Texas health and human services (HHS) agencies to consolidate twelve agencies into five in an effort to streamline organizational structures, eliminate duplicative administrative systems, and more effectively and efficiently deliver health and human services to Texans.

H.B. 2292 assigned HHSC responsibility for system policy and oversight, and the operation of several major programs. Under this consolidated structure, all HHS agencies have worked together every two years to produce a single strategic plan to address common themes and challenges across the system, and it includes the individual plans for each of the five agencies:

- 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, presented below, which was developed by the Governor, in cooperation with the Legislative Budget Board.

### 1.2 Statewide Vision—Strengthening Our Prosperity

Governor's Statement:

*Over the last year, families across this state and nation have tightened their belts in response to the economic challenges. Government should be no exception. As we begin this next round in our strategic planning process, we must critically reexamine the role of state government by identifying the core programs and activities*

*necessary for the long-term economic health of our state, while eliminating outdated and inefficient functions. We must set clear priorities that will help maintain our position as a national leader now and in the future by:*

- *Ensuring the economic competitiveness of our state by adhering to principles of fiscal discipline, setting clear budget priorities, living within our means, and limiting the growth of government;*
- *Investing in critical water, energy, and transportation infrastructure needs to meet the demands of our rapidly growing state;*
- *Ensuring excellence and accountability in public schools and institutions of higher education as we invest in the future of this state and ensure Texans are prepared to compete in the global marketplace;*
- *Defending Texans by safeguarding our neighborhoods and protecting our international border; and*
- *Increasing transparency and efficiency at all levels of government to guard against waste, fraud, and abuse, ensuring that Texas taxpayers keep more of their hard-earned money to keep our economy and our families strong.*

Rick Perry  
Governor of Texas

## **1.3 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.

## **1.4 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 government 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.

## 1.5 Statewide Goals and Benchmarks for Health and Human Services

Through this strategic plan, the HHS system addresses the priority goals and health and human services statewide benchmarks that are identified by the Governor's Office and the Legislative Budget Board and presented below.

### 1.5.1 Health and Human Services Priority Goal

*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 while reducing fraud in the 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;*

- *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; and*
- *Facilitating the seamless exchange of health information among state agencies to support the quality, continuity, and efficiency of healthcare delivered to clients in multiple state programs.*

## **HHSC**

The HHSC strategies listed in Chapter 9 address the following statewide benchmarks:

- Percentage 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;
- Percentage of eligible children enrolled in CHIP;
- Percentage of Texans receiving Temporary Assistance for Needy Families (TANF) cash assistance;
- Percentage of Texas population receiving Supplemental Nutrition Assistance Program (SNAP) benefits; and
- Number of Texans using call centers and the Internet to apply for Medicaid, SNAP benefits, and other state services.

## **DADS**

The DADS strategies listed in Chapter 9 address the following statewide benchmarks:

- Percentage 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 9 address the following statewide benchmarks:

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

## **DFPS**

The DFPS strategies listed in Chapter 9 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;
- Percentage of children in foster care who are adopted or reunited with their families; and
- Percentage of children in substitute care living with kinship care providers.

## **DSHS**

The DSHS strategies listed in Chapter 9 address the following statewide benchmarks:

- Number of children served through the Texas Health Steps Program;
- Percentage of Texas children in kindergarten who are completely immunized according to school immunization requirements;
- Infant mortality rate;
- Low birth-weight rate;
- Teen pregnancy rate;
- Percentage of births that are out-of-wedlock;
- Number of women served through Title V prenatal care services;
- Percentage 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; and
- Amount of leveraged dollars invested in state funded research grant projects.

## 1.5.2 Regulatory Priority Goal

*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 9 address the following statewide benchmarks:

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

### **DFPS**

The DFPS strategies listed in Chapter 9 address the following statewide benchmarks:

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

## **DSHS**

The DSHS strategies listed in Chapter 9 address the following statewide benchmarks:

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



# Chapter 2

## Health and Human Services System Overview

### 2.1 Introduction

The agencies in the Health and Human Services (HHS) System are interconnected by clients with multiple needs and common goals for improving the health, safety, and independence of those clients. HHS agencies administer large and small programs serving eligible populations based on some type of need—for health care, transition to self-sufficiency, nutritional assistance, rehabilitation, support for independent living, behavioral health services, and services to protect vulnerable populations from abuse, neglect, or exploitation. The Department of State Health Services (DSHS) is also responsible for public health and regulatory services and disaster response efforts, which serve all Texans. Other HHS agencies operate regulatory programs to ensure the safety and well-being of Texans in nursing homes, children in day care centers, or residents of facilities operated by the state or contracted by the state.

With greater demand for services from increasing numbers of individuals and families, the HHS agencies have developed a new framework to guide how we do business and how we support our customers while remaining accountable to taxpayers and the public at large. The current environment calls for a rethinking of priorities so that we are able to function effectively. This strategic plan includes sections that achieve the following:

- Present a vision and philosophy that will guide our work;
- Outline the Strategic Priorities to more effectively serve Texans;
- Discuss cross-agency challenges that will be addressed through deliberate assessment and action; and
- Describe the most significant accomplishments from the past two years.

The strategic plan is based on careful assessment of the economic and demographic trends that impact the external operating environment and are discussed in the following chapter. Additional information and planned activities are

addressed further in the agency strategic plans that are separate chapters of this document.

## 2.2 Health and Human Services System Vision

A customer-focused health and human services system that provides high-quality, cost-effective services resulting in improved health, safety, and greater independence for Texans.

## 2.3 Health and Human Services System Philosophy

We will work to continually improve our customer service, quality of care, and health outcomes in accordance with the following guiding principles:

- Texans are entitled to openness and 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.
- Texans should receive services in an individualized, coordinated, and efficient manner with a focus on providing opportunities to achieve greater independence.
- Stakeholders, customers, and communities must be involved in an effort to design, deliver, and improve services and to achieve positive health outcomes and greater self-sufficiency.

## 2.4 Health and Human Services System Strategic Priorities

### 2.4.1 Improve the health and well-being of Texans.

- Emphasize health promotion, primary care, disease prevention, and early intervention for improved long-term health outcomes.
- Improve access to services that address behavioral health needs.
- Provide an outcome-based, quality-oriented system of care.
- Develop cost containment strategies for Medicaid, CHIP, and other programs to ensure sustainability of services.

## **2.4.2 Create opportunities for increased self-sufficiency and independence.**

- Ensure that policies and services encourage employment and individual responsibility.
- Partner with persons with disabilities in overcoming barriers to full participation in the community and the labor market.
- Assist older Texans and those with disabilities to gain, maintain, and enhance their ability to function independently.
- Ensure that children who have developmental delays enjoy the same opportunities as other Texans to pursue independent and productive lives.

## **2.4.3 Protect vulnerable Texans from abuse, neglect, and exploitation.**

- Ensure the safety and well-being of Texans in state-operated and contracted residential facilities, as well as those served in their homes.
- Improve our ability to detect potential risk to vulnerable children and adults in the community.
- Ensure that licensing and regulatory authorities hold public and private sector providers accountable for the health and safety of clients.

## **2.4.4 Deliver the highest quality of customer service.**

- Provide benefits accurately and on time.
- Improve agency business practices to create a more coordinated, cost-effective, and customer-friendly service delivery system.

## **2.4.5 Encourage partnerships and community involvement.**

- Develop partnerships with families, stakeholders, community organizations, providers, and others in the public to address service delivery issues and ensure customers receive timely, appropriate services.
- Work closely with local food banks and other organizations to assist people in applying for nutrition, medical, and cash assistance, and other critical service needs.
- Continue to develop and improve volunteer programs to support service delivery.

## 2.4.6 Strengthen and support the health and human services workforce.

- Recruit high-quality staff.
- Increase retention by providing opportunities for continued learning and career advancement.
- Recognize and reward employee performance.
- Encourage employees to work together across agencies to achieve common goals.

## 2.5 Health and Human Services System Challenges

The internal and external analyses conducted for this strategic planning cycle revealed several common challenges that all HHS agencies are facing.

- Addressing growth in the need for services,
- Increasing focus on regulatory effectiveness,
- Maintaining and developing the workforce,
- Addressing infrastructure needs,
- Improving data quality and use, and
- Evaluating impact of federal health care reform requirements on current health and human services system.

Not all of these challenges are new, but they have become more urgent due to the economic downturn and the resulting significant increases in the number of clients applying for and enrolling in HHS programs. In addition to this growth, the short- and long-term requirements of federal health care reform will result in very large numbers of clients being added to the Medicaid program. Other programs will be impacted as well, possibly in ways not yet understood. Finally, there is increasing emphasis on the system's ability to regulate effectively not only services provided by HHS agencies, but also larger systems such as child care facilities, long-term care nursing facilities, and even the safety of our food supply.

These external challenges amplify the need for the system to address pressing key internal challenges, which include:

- The HHS **workforce** must be continually developed and trained to enhance skill levels. Strategies to deal with the retirements of many experienced workers must also be in place.
- In order to support the workforce and client service delivery, significant investments in **infrastructure** will be required, including the completion of key technology projects, for example, the statewide roll-out of TIERS.

Finally, the system will need **high-quality data** and the capacity to use it appropriately in order to effectively assess program performance, make timely changes as needed, budget wisely, evaluate our efforts, and plan for the future.

**Figure 2.1.**  
**HHS System Challenges**



**Figure 2.1: Health and Human Services Commission, Center for Strategic Decision Support.**

In sum, the internal and external challenges are interdependent, and all need strategic attention in order to effectively address HHS challenges over the next five years. These challenges are addressed in agency plans, which describe them in more detail from each agency’s perspective, and which include planned actions. The new Executive Commissioner’s operational planning and executive management briefing process described in the HHSC Strategic Plan Chapter 4 will ensure accountability and coordination across agencies.

## **2.6 Major Accomplishments of the Health and Human Services System**

### **2.6.1 STAR Health**

STAR Health resulted from requirements in Senate Bill 6, 79<sup>th</sup> Legislature, Regular Session, 2005, directing HHSC to work with the Department of Family and

Protective Services (DFPS) to develop a medical care delivery system for children in foster care. HHSC, in collaboration with DFPS, implemented the STAR Health Program in April 2008.

STAR Health is now a statewide program providing coordinated health services to children and youth in foster care and kinship care. STAR Health serves children as soon as they enter state conservatorship and continues to serve them in two transition categories:

- Young adults up to 22 years of age with voluntary foster care placement agreements; and
- Young adults younger than 21 years of age who were previously in foster care and are receiving transitional Medicaid services.

HHSC administers the program under contract with a single managed care organization. STAR Health members receive medical, dental, and behavioral health benefits, including unlimited prescriptions, through a medical home. Clients begin receiving services as soon as they enter state conservatorship.

Children in foster care are a high-risk population with greater medical and behavioral health care needs than most children in Medicaid. STAR Health covered services include: physical and behavioral health, dental services, service coordination, clinical service management, disease management, and telephone help lines for member and provider assistance.

Highlights of the program delivery model include:

- Expedited enrollment into the model so that needed services are immediately available;
- A medical home through a primary care provider (PCP) to coordinate care and promote better preventive health care efforts;
- Service coordination and service management to assist children and their caregivers with accessing services and PCPs with coordinating health care services among the child's various health care providers;
- Improved access to services through a defined network of providers;
- Improved access to a child's health history and medical information via a Web-based Health Passport;
- A 7-day, 24-hour nurse hotline for caregivers and caseworkers;
- A medical advisory committee to promote provider performance;
- Recruitment of historical and additional providers that can provide Medicaid services to children in foster care;
- Psychotropic Medication Utilization and Review (PMUR) process to screen all foster children receiving psychotropic medications for compliance with DSHS prescribing guidelines. The PMUR process has resulted in a decrease in the number of foster children who have taken prescription psychotropic

medications for 60 days or more and a decrease in the practice of polypharmacy with foster children.

## **2.6.2 Texas Promoting Independence Initiative and Plan**

The Texas Promoting Independence Initiative was implemented 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 choice for individuals who are older or have disabilities to live in the most integrated residential setting desired and to receive appropriate long-term services and supports. While this is an HHSC initiative, daily management of the initiative has been delegated 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 to make recommendations regarding services for individuals with disabilities. HHSC established the statewide advisory committee, Promoting Independence Advisory Committee (the Committee), to guide the development of this report, named the "Texas Promoting Independence Plan" (the Plan).

The latest Plan is the "2008 Revised Texas Promoting Independence Plan," published in 2009. A new plan will be submitted in December 2010, prior to the 82<sup>nd</sup> Legislative Session. 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 HHS enterprise-wide issues that may be a barrier to an individual's choice to live in the most integrated setting desired.

Several collaborative, interagency initiatives that DADS will be continuing or initiating involve HHSC and the other HHS agencies that support individuals with disabilities living in the most integrated residential setting. These initiatives promote choice and self-determination.

One major systems change that resulted from this initiative is the "Money Follows the Person" (MFP) policy, which began on September 1, 2001 as the result of a rider to the General Appropriations Act, and was codified in statute effective September 1, 2005. This policy helps individuals who are receiving long-term services and supports in a nursing facility (NF) return to the community to receive services without placement on certain Medicaid waiver program interest lists. In order to access the MFP program, an individual must:

- Be Medicaid-eligible;
- Have been living in a Medicaid-certified NF for 30 days; and
- Meet all the program eligibility criteria for the community-based waiver program.

The MFP program has been very successful: since the program's inception, 20,300 Texans have used the program to relocate back to their communities to receive long-term services and supports.

The initiative also allows individuals in nine-or-more-bed private community Intermediate Care Facility for Persons with Mental Retardation (ICFs/MR) or in State Supported Living Center (SSLCs) to have expedited access to the Home and Community-Based Services (HCS) waiver. Individuals in SSLCs may access an HCS slot within six months of referral, and those residing in private community ICFs/MR may access an HCS slot within 12 months of referral.

Texas MFP is anticipated to receive up to \$30 million in enhanced Medicaid funding through 2012 for a Texas MFP Demonstration. Texas was one of the original grantees to receive funding from the \$1.8 billion national demonstration program allocation that was included in the Deficit Reduction Act (DRA) as the MFP Rebalancing Demonstration.

The Texas MFP Demonstration has set a benchmark to relocate 2,999 additional individuals who are current residents of the following institutions:

- NFs;
- Nine-or-more-bed private ICFs/MR;
- SSLCs; and
- Nine-or-more-bed private ICFs/MR whose providers want to close their facilities.

In addition to targeting the above-mentioned populations, four specialized projects are part of the Demonstration.

- **Behavioral Health Pilot:** Individuals in Bexar County receive two new Demonstration services: cognitive adaptation training and adult substance abuse training services. The Department of State Health Services (DSHS) coordinates this initiative.
- **Post-Relocation Contacts:** Relocation specialists are providing intensive post-relocation contacts with individuals to provide outside support and continuity with the relocation.
- **Overnight Companion Services:** Individuals in all fee-for-service counties in Region 11 (Lower South Texas) and all counties in Region 4 (Upper East Texas) who have complex functional or medical needs are 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-Bed Community ICFs/MR:* Providers of these facilities have an opportunity to work with DADS to voluntarily close their facilities. All residents of these facilities are given freedom of choice on where they want to live in terms of community settings or another ICF/MR.

The Patient Protection and Affordable Care Act of 2010 (Act) has extended the MFP Demonstration program's original appropriations an additional five years through 2016. The Act also reduces the eligibility requirement for a participant to be in an institution from 180 days to 90 days before relocation can occur, within certain guidelines. The program is in the process of evaluating the potential impact of these new provisions.

### **2.6.3 Office of Inspector General Funds Recovery and Cost Avoidance**

The 78<sup>th</sup> Legislature created the Office of Inspector General (OIG) in 2003 to strengthen HHSC's authority and ability to combat waste, abuse, and fraud in HHS programs. Since its creation, the OIG has recovered or avoided more than \$4.6 billion in health and human services costs.

Authorized by Section 531.102 of the Texas Government Code, OIG is responsible for the investigation of waste, abuse, and fraud in the provision of HHS programs. OIG aggressively recovers money that was improperly spent in the provision of health and human services, for a total of \$2.3 billion since its inception.

OIG also takes proactive measures to reduce errors in the billing, payment, and adjudication of claims for Medicaid services. OIG administers training on preventing waste, abuse, and fraud for Medicaid providers, health maintenance organizations, claims administrator staff, and provider organizations. OIG staff actively participates in medical and program policy recommendations to reduce erroneous payments while maintaining or improving quality of care to Medicaid recipients. These proactive efforts have allowed OIG and HHSC to increase cost-avoidance activities and sustain improved relationships with Medicaid providers. Costs avoided since the OIG's creation total \$2.3 billion.

### **2.6.4 Novel H1N1 Influenza Preparedness and Response**

In April 2009, the state experienced the first wave of the 2009 novel H1N1 influenza pandemic, the first pandemic in more than 40 years. As the lead agency for public health preparedness and response, DSHS worked with key partners in an effort to successfully respond to this unprecedented challenge: Office of the Governor, HHSC, Texas Division of Emergency Management, University of Texas Medical Branch, Texas Education Agency, Texas Department of Agriculture, regional and local public health agencies, and federal partners including the Centers for Disease Control and Prevention (CDC), Department of Health and Human Services, and Office of the Assistant Secretary for Preparedness and Response.

In response to the increasing cases of H1N1 influenza outbreak, the Governor of Texas requested assets from the Strategic National Stockpile to supplement the

state's existing caches of antivirals and personal protective equipment. DSHS response activities for both pandemic waves in Texas were coordinated using the Multi-Agency Coordination Center (MACC) staffing structure, which was based on the successful processes used for response to natural disasters such as hurricanes.

These relationships and actions provided the fundamental framework to facilitate an effective and timely response. Texas was one of the first states to be impacted by the outbreak and ultimately had more cases of novel H1N1 infection in one Health Service Region along the border than 44 states combined. DSHS epidemiologists, together with federal partners, were instrumental in characterizing the epidemic, and the Texas response team provided innovative solutions for the distribution of antiviral medications through retail pharmacy chains, in the absence of a vaccine.

Immediately after the first wave, a comprehensive after-action review was performed to improve the state's response in preparation for the second wave. Teams worked to improve DSHS response operations, epidemiologic and laboratory surveillance, antiviral and vaccine distribution plans, non-pharmaceutical interventions (recommendations and guidance for school closures, for example), and risk communications, as well as an ethics advisory committee. The improvement process culminated in a statewide summit in August 2009, where more than 625 participants attended, and 13 regional meetings across the state, with more than 2,500 individuals participating.

In September 2009, the second wave of the 2009 novel H1N1 influenza pandemic began, and the wave diminished as the year came to an end. The successful Texas response was largely supported by investments of the 81<sup>st</sup> Legislature for the purchase of additional supplies of antiviral medications and response funding of approximately \$93 million from the CDC and \$7 million from the Office of the Assistant Secretary for Preparedness and Response. These resources enabled DSHS to:

- Distribute approximately 10 million doses of H1N1 vaccine to more than 11,000 providers across the state;
- Provide the Texas antiviral stockpile to more than 1,400 retail and independent pharmacies in 207 counties, covering 99 percent of the states population;
- Create [www.texasflu.org](http://www.texasflu.org) as the primary platform for information pertaining to H1N1, and with 2-1-1 Texas Information and Referral Network used as the single resource for credible public information;
- Launch media campaigns; and
- Increase capacity for medical surge, epidemiology, and laboratory surveillance.

As a result of state planning and activities, Texas received recognition as one of the states most prepared for a pandemic influenza.

## **2.6.5 Cancer Registry**

The Texas Cancer Registry (TCR) is a statewide population-based registry that serves as the foundation for measuring the Texas cancer burden, comprehensive cancer control efforts, health disparities, progress in prevention, diagnosis, treatment, and survivorship, and it also supports a wide variety of cancer-related research. These priorities cannot be adequately addressed in public health, academic institutions, or the private sector without timely, complete, and accurate cancer data.

The TCR is the fourth-largest cancer registry in the United States, and it currently meets the National Program of Central Cancer Registries, Centers for Disease Control and Prevention high-quality data standards, and is Gold Certified by the North American Association of Central Cancer Registries. The Gold Standard was first attained by the Texas Cancer Registry in 2006, and is an annual certification process.

The ultimate goal and purpose of the TCR is to collect, maintain, and disseminate the highest quality cancer data that will contribute towards overall public health, cancer prevention and control, improving diagnoses, treatment, survival, and quality of life for all cancer patients.



# Chapter 3

## Health and Human Services System Operating Environment

### 3.1 Statewide Demographic, Economic, and Health Trends

Key demographic trends and changing economic conditions affect the complex environment in which the health and human services (HHS) agencies operate. Projected changes in the size, composition, and geographical distribution of the population will likely have a strong impact on agencies and programs. Key demographic trends to watch include the aging of the population, increased longevity, and more race/ethnic diversity.

It is projected that in coming years, the age structure of the population will change dramatically, as the percent share of the population that is age 65 and older increases. Additionally, with continued advances in medicine, those who reach the age of 65 will have a greater likelihood of living past the age of 85. Thus, the population of people age 85 and older is likely to increase as a percent share of the total population. The race/ethnic composition of the population is projected to change, as the percent of the total population that is Anglo decreases and the percent that is non-Anglo increases.

Rapidly changing economic conditions have had an impact on the demand for health and human services. Due to the economic recession that started in 2007, key health and human services programs such as Medicaid, Children's Health Insurance Program (CHIP), and the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) have experienced caseload increases that are much higher compared to what had been projected two years ago. Similarly, other important programs, such as those administered by the Texas Department of Family and Protective Services (DFPS), have also experienced unanticipated caseload increases.

The discussion ahead addresses the key demographic and economic trends that could impact agencies and programs in the Texas Health and Human Services

system in the years ahead. The implications of these trends and impacts are discussed later in the agency chapters, Chapters 4-8.

The demographic terminology used in this Plan is consistent with the terminology used by the Texas State Data Center (SDC), with the exception that in discussing race/ethnicity, this Plan uses “African American” (and “African-American” as an adjective) whereas the SDC uses “Black.” Below is a list of race/ethnic terms with their respective definitions, as used in the Plan:

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

### 3.1.1 Demographic Trends

#### Population Growth<sup>1</sup>

Since becoming a state in 1846, Texas has consistently experienced higher population growth compared to the rest of the nation. This rapid growth has accelerated during the last 30 years and continues to be very strong today. From 1980 to 2010, the state’s population grew from 14.2 to 25.4 million, for a growth rate of 79 percent. This growth rate is almost twice as high as the growth rate for the United States (U.S.) as a whole.<sup>2</sup> During that time, the Texas share of the national population grew from 6 percent of the total to 8 percent.<sup>3</sup> With a total population already surpassing 25 million, Texas ranks second in total population, after California, which in 2009 had a population of nearly 37 million.

The U.S. Census Bureau estimates that from 2000 to 2009 the state’s population grew by 3.9 million. According to the Bureau’s analysis, natural increase (population growth resulting from the birthrate being greater than the number of deaths) accounted for 54 percent of the growth, while positive net migration (population growth resulting from the number of incoming migrants being greater than number of outgoing migrants) accounted for 46 percent. Among the almost 1.8 million persons

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<sup>1</sup> The SDC is the source for Texas population projections data cited in this Plan. The SDC develops different sets of population projections based on different assumptions concerning future population growth. Although all the projection scenarios use the same assumptions regarding age/race-ethnic specific fertility and mortality rates, each of the scenarios assume different rates of net migration for projecting the population. After Hurricane Katrina struck in 2005, the SDC developed a population projection scenario that measures the impact that the mass migration into Texas of hundreds of thousands Hurricane Katrina evacuees is likely to have on future growth trends. This scenario is known as the 2000-2007 Migration Scenario. The population projections for Texas cited throughout this Plan are derived from this scenario.

<sup>2</sup> Texas State Data Center.

<sup>3</sup> Ibid.

who moved into the state during this period, approximately 52 percent or 933,000 were international migrants. It is expected that both international and domestic migration will continue to make significant contributions to population growth during the upcoming planning period.<sup>4</sup> The SDC projects that Texas' total population will reach 26 million in 2011, and will grow by 8.2 percent to reach 28 million in 2015.<sup>5</sup>

### **Aging of the Population**

The SDC projects a dramatic shift in the age structure of the population in the coming decades. Although this plan focuses on short-term trends, for the years 2011-15, it is useful to discuss potential long-term trends. The population age 65 and older is projected to increase from 2.6 million in 2011 to 7.5 million in 2040. The percentage of the total population that is 65 years of age or older is projected to increase from 10 percent in 2005 to 17 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 2011 to 2.2 percent by 2040.

The median age for the Texas population as a whole, which stood at 33.2 years during the Census of 2000, is projected to increase to 37.8 years in the year 2040.<sup>6</sup> The median age is projected to increase for all major race/ethnic groups.

Although the population age 65 or older is projected to grow across all race/ethnic groups, the growth will be more dramatic in the non-Anglo groups. Between 2011 and 2040, the following growth rates are projected in the population of persons age 65 or older:

- Anglos: 91 percent;
- African Americans: 236 percent;
- Hispanics: 422 percent; and
- All other groups (combined): 1,144 percent.

Figure 3.1 depicts the projected growth trend for the population age 65 and older during the 2011-40 period according to race/ethnicity. In the 65 and older population, the Anglo population is projected to grow from 1.7 million to 2.8 million; the African-American population is projected to grow from 222,000 to 700,000; and the Hispanic population is projected to grow from 530,000 to 2.7 million. For all other groups combined, the population is projected to grow from 105,000 to 1.3 million over the same period.

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<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

**Figure 3.1**  
**Texas Population Age 65 and Older by Race/Ethnicity 2011-40**

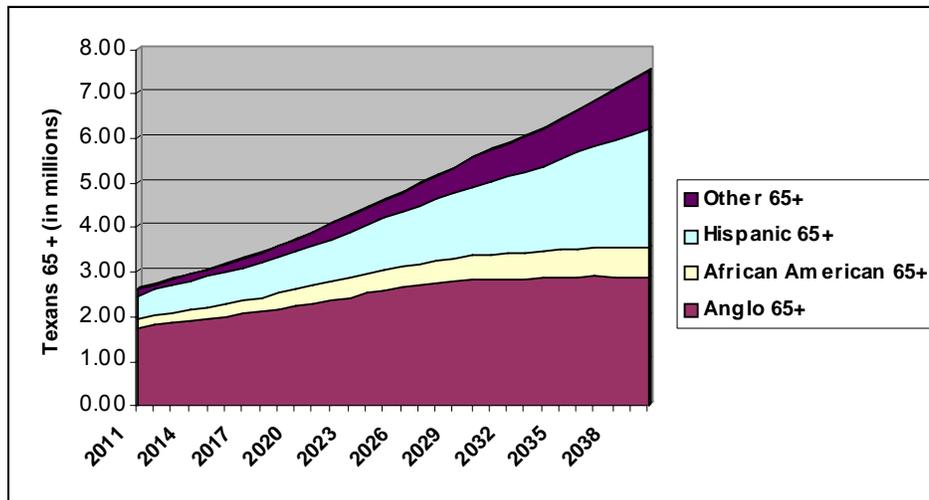


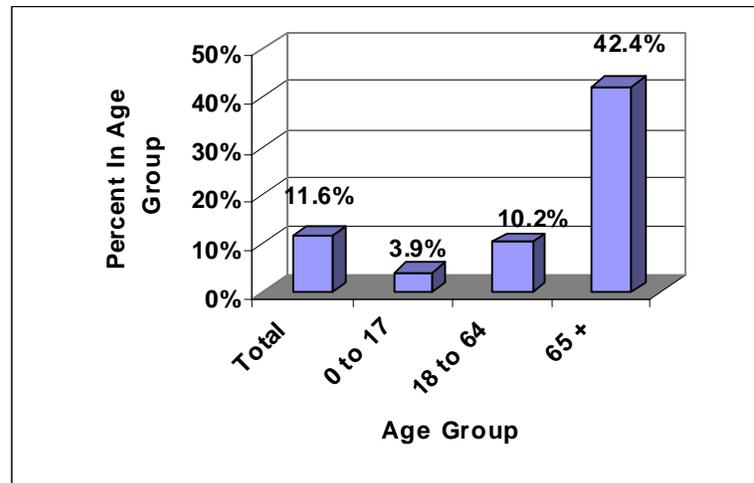
Figure 3.1. Texas State Data Center; HHSC Strategic Decision Support.

### Prevalence of Disability

With the gradual aging of the population will likely come an increase in the number of people with a disability or other chronic health condition, which can cause difficulties in performing basic activities of daily living and functions, such as working, bathing, dressing, cooking, and driving. People with disabilities or chronic health conditions are more likely to need and use health and human services, so this trend could mean increased demand for the HHS agencies.

The American Community Survey (ACS) for Texas, which is conducted by the U.S. Census Bureau, indicates that in 2008 there were approximately 2.8 million, or 11.6 percent, of Texans who lived with a disability. Among adults aged 18-64, the ACS reports that only 10.2 percent had a disability in 2008. However, among adults aged 65 and older, the ACS reports that 42.4 percent live with a disability. Figure 3.2 illustrates the percent of the population with a disability according to age group.

**Figure 3.2**  
**Percent of Texans with Disability within Selected Age Groups**



**Figure 3.2. U.S. Census Bureau, American Community Survey, 2008; HHSC Strategic Decision Support.**

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

The SDC projects that the non-Anglo population of the state will grow at a faster rate than the Anglo population

In 2011, Anglos are projected to comprise 44.3 percent of the population, while Hispanics are projected to comprise 38.8 percent. African Americans are projected to comprise 11.5 percent, and other groups are projected to account for the remaining 4.6 percent.

The SDC projects the following growth trends between 2011 and 2015:

- The Anglo population is projected to grow from 11.5 to 11.6 million, for a growth rate of less than 1 percent.
- The African-American population is projected to grow from 3.0 to 3.2 million, for a growth rate of 7.1 percent.
- The Hispanic population is projected to grow from 10.2 to 11.8 million, for a growth rate of 21.2 percent.
- The population of all other population groups (combined) is projected to grow by 971,000 to 1.2 million, for a growth rate of approximately 20 percent.

The high growth rate projected for the non-Anglo populations, which historically have experienced a higher rate of poverty, could further accelerate the demand for services. Key areas such as public health could be affected as certain diseases and

health conditions tend to be more prevalent in some racial-ethnic groups compared to others—for example, Type II Diabetes among Hispanics.<sup>7</sup> The implications of some of these dynamics are discussed in more detail later in this chapter and in Chapter 8, the Department of State Health Services Strategic Plan.

### **Rural Population Concerns**

The trend toward greater urbanization in Texas is expected to continue during the foreseeable future. Based on the U.S. Office of Management and Budget classification, there are 77 counties in the state that are classified as metropolitan while 177 are classified as non-metropolitan.<sup>8</sup> The SDC projects that in 2011, approximately 3.2 million or 12.4 percent of the total population of 25.9 million will reside in non-metropolitan counties, while 22.7 million or 87.6 percent of the total population are projected to reside in metropolitan counties. According to the SDC, between 2011 and 2015 non-metropolitan counties will add approximately 83,000 new residents, while metropolitan counties are projected to add another 2 million.

Counties or areas that are more rural and isolated tend to experience particular challenges for the delivery of health and human services, with residents facing many of these challenges:

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

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<sup>7</sup> Texas Behavioral Risk Factor Survey (<http://www.dshs.state.tx.us/chs/brfss/>).

<sup>8</sup> The U.S. Office of Management and Budget (OMB) classifies counties as metropolitan or non-metropolitan based on analysis of population density and commuting-to-work patterns, as reported by the U.S. Census Bureau. Counties that the OMB classifies as metropolitan are known as 'Central' counties that have a major regional population center (can be a city or twin city) with a population of 50,000 or more, plus any surrounding counties whose residents have a high degree of economic integration with the 'Central' county, as revealed by commuting-to-work data collected by the Census Bureau. All other counties that do not fit this definition are classified as non-metropolitan. The more rural and isolated counties tend are typically classified as non-metropolitan.

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### 3.1.2 Economic Forecast

The last two years have been a difficult period for the nation, as economic downturns tend to bring additional demand for social services at a time when the amount of revenue available to fund additional services is more limited.

According to the latest employment statistics reported by the Texas Workforce Commission, the state lost approximately 106,000 non-farm jobs in 2009 and is projected to lose an additional 127,000 in 2010. The number of unemployed Texans reached near one million in December 2009, for an unemployment rate of 8.2 percent. The average Texas household income has declined during the last two years, measured on an inflation-adjusted basis.

It is expected that the Texas labor force, which stood at 10.5 million in December 2009, will grow during the planning period and beyond, as the SDC projects that the population of working age persons will continue growing.

There are early signs that some sectors of the economy are beginning to grow and to add new jobs. Analysts suggest that the unemployment rate may have reached its peak in December 2009, both in Texas and nationally. That month, the rate of unemployment in Texas was 8.2 percent, compared to 10.0 percent in the U.S.<sup>9</sup> Labor Market analysts also suggest that it is unlikely the rate of unemployment will return to pre-recession levels within the span of the upcoming planning period.<sup>10</sup>

The key to additional job growth will be a prolonged and sustained recovery that touches multiple sectors of the economy. Improved economic conditions that support a strengthened job market will probably help reduce the growth rate seen in many HHS programs during the last two years as a result of the recession.

#### Poverty

People living in poverty often rely on health and human services, so it is useful to analyze poverty population growth trends for potential impacts on the HHS system.

The U.S. Department of Health and Human Services defined the poverty level for 2009 as an annual gross income as follows:

- \$22,050 or less for a family of four,
- \$18,310 or less for a family of three,
- \$14,570 or less for a family of two, and
- \$10,830 or less for individuals.

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<sup>9</sup> Texas Workforce Commission.

<sup>10</sup> HIS Global Insight. April 30, 2010. "A Multi-Speed Global Expansion: Prospects for the U.S. Economy."

According to the U.S. Census Bureau's March 2009 Current Population Survey (CPS) for Texas, an estimated 3.8 million Texans, or 15.9 percent of the population, lived in families with annual incomes falling below the federal poverty level in 2008.<sup>11</sup> Based on the March 2009 CPS, HHSC staff project that in 2011 approximately 4.0 million Texans, or 15.3 percent of the population, will live in families with annual incomes below the poverty level. For the child population under the age of 18, it is projected that 22 percent will live in families with incomes below the poverty level in 2011, a figure that is likely to increase to 23 percent by 2015.

### **Poverty and Race/Ethnicity**

The percent of the population below the poverty level varies by race and ethnicity. In 2011, 6.7 percent of Anglos are projected to be living in poverty, compared to 19.4 percent of African Americans, 24.0 percent of Hispanics, and 13.6 percent of other groups. These percentages are not projected to change significantly during the planning period.

The percent of the child population younger than age 18 living below poverty also varies by race and ethnicity, with the percentages being higher for non-Anglo children. In 2008, 8.0 percent of Anglo children lived in families with annual incomes below the federal poverty level, compared to 27.0 percent of African-American children, 31.6 percent of Hispanic children, and 17.9 percent of children in other groups.

## **3.1.3 Health Trends**

### **Health Insurance Coverage**

The U.S. Census Bureau's March 2009 CPS gathered health insurance coverage information for 2008, as follows.

- There were 6.1 million Texas residents without health insurance, counting both citizens and non-citizens.
- This number represented 25 percent of the Texas population, the highest percentage of any state in the nation.
- Among the 75 percent of Texas residents who had health insurance, the most prevalent form of coverage was employer-based private insurance.
- Approximately 52 percent of the Texans younger than age 65 had employer-based health insurance.
- More than 95 percent of the population age 65 and older was covered by Medicare.
- An estimated 18 percent, or 1.2 million Texas children, were uninsured.

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<sup>11</sup> U.S. Census Bureau, March 2009 Current Population Survey (CPS) for Texas.

In recent years, the percentage of the population younger than age 65 who had private health insurance coverage has declined both nationally and in Texas. In Texas, the percent of the population covered by any type of private insurance declined from 65 percent in 2000 to 57 percent in 2008. Compared to other states, Texas had the second lowest percentage, after New Mexico, for private health insurance coverage among persons under the age of 65 in 2008.

The percentage of children younger than age 18 who had private health insurance also varied according to race/ethnicity in 2008, when approximately 74 percent of Anglo children were covered by private health insurance while only 47 percent of African-American and 31 percent of Hispanic children were covered by private health insurance.

Among the public insurance programs, Medicaid and CHIP, both operated by the State, have experienced increased enrollment levels during the last two years due to the economic recession. In September 2009, approximately 2.9 million low-income children younger than age 19 were enrolled in Medicaid and CHIP, nearly 42 percent of all the children in the state. This level was an increase of approximately 500,000 children since September 2007.

Federal health care reform is expected to have a major impact on the size of the population that is served by the Medicaid program. It is also expected that the number and percentage of people who are uninsured will decline due to the implementation of federal health care reform. Beginning in 2014, Texas could see an additional 1.8 million clients enrolled in the Medicaid program. From 2014 to 2023, persons coming into the program under federal mandates could cost Texas approximately \$18.1 billion in general revenue funds; with federal matching funds added, the total cost could reach \$161.8 billion.<sup>12</sup>

### **Impact of Natural Disasters**

Hurricane Ike struck the Texas Gulf Coast in September 2008, causing billions of dollars in damage to homes, infrastructure, and economic activity on which people rely for their health and well-being. This devastation placed Hurricane Ike on record as the third most costly storm in U.S. history. The loss of economic activity in the wake of the destruction also caused hardship, and continues to cause it.

Tens of thousands of residents were displaced from their homes, either temporarily or permanently. The hurricane stopped the electrical and water supply to as many as 12 million people during the hurricane itself and in the days immediately following. Entire communities on the Bolivar Peninsula were completely flooded and destroyed. Approximately 4,000 were completely destroyed, and an additional

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<sup>12</sup> HHSC. April 22, 2010. "Federal Health Care Reform – Impact to Texas Health and Human Services," Presentation to the House Select Committee on Federal Legislation. (<http://www.hhsc.state.tx.us/news/presentations/2010/HouseSelectFedHlthReform.pdf>).

103,000 homes were significantly damaged, in the areas that were most severely impacted by the hurricane.<sup>13</sup> Six hospitals in the greater Houston metropolitan area and three in the greater Beaumont area suffered significant damage. The University of Texas Medical Branch in Galveston alone is estimated to have sustained approximately \$1 billion in damages.<sup>14</sup> Medicaid-certified nursing homes lost much of their bed capacity, including up to a 45 percent loss in Chambers County.

This damage caused severe strains on community capacity to provide health and human services, including: basic health care, specialty health services, child care, public education, and senior support systems. Hurricane Ike compounded the impacts on individuals with disabilities, older people, and others with special needs, as they rely on the support of others.

The state was able to respond quickly and efficiently and provided many of the emergency social and health services to support the populations most directly impacted by the hurricane. State and federal funding continues to provide social and health services in affected communities.

Longer-term, these communities may continue to face challenges in areas such as mental health, individual physical health, and a variety of epidemiological hazards.<sup>15</sup> Health and human services agencies must plan and act efficiently to ensure that services are provided to those in need, even under the stressful and very difficult conditions that accompany natural disasters. See Chapter 8, Section 8.3.3, Improving Response to Public Health Threats and Disasters, for a description of Texas efforts to prepare for natural disasters and other hazardous events.

## Health Risk Factors

In 2006, chronic diseases account for a majority of the leading causes of death in the U.S. and in Texas. Chronic diseases are generally characterized by a long period of development, a prolonged course of illness, non-contagious origin, functional impairment or disability, multiple risk factors, and low curability. Table 3.1 provides information relating to the 10 leading causes of death in Texas in 2006.

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<sup>13</sup> FEMA 2008 [http://www.fema.gov/pdf/hazard/hurricane/2008/ike/impact\\_report.pdf](http://www.fema.gov/pdf/hazard/hurricane/2008/ike/impact_report.pdf).

<sup>14</sup> University of Texas Medical Branch. June 9, 2010. "UTMB Update on Hurricane Ike Recovery," Presentation to the Senate Finance Committee (<http://www.utmb.edu/iutmb/pdfs/SenFin%20presentation--REV%206-4-10.pdf>).

<sup>15</sup> National Hurricane Center, "2009 Atlantic Hurricane Season" <http://www.nhc.noaa.gov/2009atlan.shtml>.

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**Table 3.1  
 Leading Causes of Texas Deaths, 2006**

<b>Ranking</b>	<b>Disease</b>	<b>Percentage</b>
<b>1</b>	Heart Diseases	24.6%
<b>2</b>	Cancer	22.2%
<b>3</b>	Stroke-Related	6.0%
<b>4</b>	Accidents	5.8%
<b>5</b>	Lung Diseases	4.9%
<b>6</b>	Diabetes-Related	3.3%
<b>7</b>	Alzheimer's Disease	3.1%
<b>8</b>	Influenza and Pneumonia	2.1%
<b>9</b>	Kidney Disease	1.7%
<b>10</b>	Blood Infections	1.7%
All Other Causes		24.4%
<b>Total Deaths in 2006</b>		<b>100.0%</b>

**Table 3.1. Department of State Health Services.**

Five of the top six leading causes of death in Texas in 2006 have several risk factors in common. Cardiovascular Disease includes heart disease, stroke, and congestive heart failure; its risk factors include hypertension, tobacco use, high cholesterol levels, physical inactivity, poor nutrition, obesity, and second-hand tobacco smoke. Cancer represents more than 100 distinct diseases that are all characterized by the uncontrolled growth and spread of abnormal cells in the body; risk factors associated with cancer include tobacco use, poor nutrition, physical inactivity, and obesity. Diabetes can lead to disabling health conditions such as heart disease, stroke, kidney failure, leg and foot amputations, and blindness; its risk factors include poor nutrition, physical inactivity, and obesity.

Understanding these risk factors can help in developing strategies to reduce the impact of preventable or treatable chronic conditions. These risk factors are tracked at the state and national levels to better understand the health status of populations and to inform policymaking. They are:

- Physical activity,
- Obesity,
- Tobacco use,
- Substance use,
- Responsible sexual behavior,
- Mental health,
- Injuries and violence,
- Immunizations,
- Environment, and
- Access to health care.

## **Mental Health**

Mental illnesses are a leading cause of disability in the U.S., Canada, and Western Europe. In general, 19 percent of the adult U.S. population have a mental disorder alone, during the course of one year; 3 percent have both mental and addictive disorders. In Texas, the 2009 estimated number of adults with serious and persistent mental illness was 467,226. Approximately 20 percent of children are estimated to have mental disorders with at least mild functional impairment. Federal regulations also define a sub-population of children and adolescents with more severe functional limitations, known as “serious emotional disturbance” (SED). Children and adolescents with SED comprise approximately 5 to 9 percent of children ages 9 to 17.<sup>16</sup>

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. The health-care system has not kept pace with people’s diverse needs. Minority populations are often underserved or served inappropriately. The Office of the U.S. Surgeon General reports that compared to Anglos, racial and ethnic minorities are less likely to receive mental health services, to have health insurance, or to receive high-quality

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<sup>16</sup> <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

care for a mental illness. Minorities are over-represented among those who have a mental disorder and are homeless, incarcerated, or institutionalized. Disparities in care also affect residents of underserved or rural areas.

## **Behavioral Risk Factors**

In Texas, each of the seven leading causes of death can be linked to one or more significant behavioral risk factors. Three risk behaviors are the major contributors to cardiovascular disease and cancer: tobacco use, poor nutrition, and physical inactivity. The Texas Behavioral Risk Factor Surveillance System (BRFSS) takes an in-depth look at behavioral risk factor prevalence in Texas and reports the following information.<sup>17</sup>

Tobacco use, including cigarette smoking and the use of other tobacco products, takes a significant toll, killing an estimated 24,000 Texans each year. The following statistics characterize smoking in Texas:

- Fewer than one in four Texas adults currently smokes;
- Both nationally and in Texas, among adults:
  - Anglos 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 2008, 8.9 percent of middle school students and 19.8 percent of high school students smoked cigarettes on at least one of the 30 days preceding the survey; and
- Anglo and Hispanic high school students were more likely to smoke than African Americans, while among middle school students, Hispanics and African Americans were more likely to smoke than Anglos.

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.

- Obesity rates are rising in Texas. In 2009, 66.7% of Texas adults were overweight or obese, compared to 62.4% in 2006.<sup>18</sup>
- 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.

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<sup>17</sup> Department of State Health Services (<http://www.dshs.state.tx.us/chs/brfss/default.shtm>).

<sup>18</sup> 2009 Texas Behavioral Risk Factors Surveillance System, Center for Health Statistics, Department of State Health Services. Available online at: [http://www.dshs.state.tx.us/chs/brfss/query/brfss\\_form.shtm](http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm).

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- Compared to the other U.S. states, Texas has a high average rate of obesity in the adult population.
  - 37.2 percent of Texans report a Body Mass Index (BMI)<sup>19</sup> that classifies them as overweight, compared with 36.2% nationwide.
  - 29.5 percent of Texans report a BMI that classifies them as obese, compared to 26.9% nationwide.
  - Texas has the 14<sup>th</sup>-highest percentage of obese adults and 20<sup>th</sup>-highest percentage of obese and overweight children in the U.S.<sup>20</sup>
- 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 fourth grade and eleventh grade.

Regular physical activity, even in moderate amounts, has been shown to produce significant health benefits. Despite this fact, the BRFSS showed that in 2008 many adults in Texas reported little or no exercise.

- In Texas, 28.5 percent of adults reported no leisure-time physical activity in the past month, compared to 24.6 percent of adults nationwide.
- Of Hispanics in Texas, 34.5 percent reported no physical activity, compared to 30.3 percent of African Americans and 24 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.<sup>21</sup>
- According to the Youth Risk Behavior Surveillance System in 2009, 36.3 percent of Texas adolescents in grades nine through twelve watched television for three or more hours per day on an average school day, compared with 32.8 percent nationwide.

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

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<sup>19</sup> The formula for Body Mass Index is weight (lb) / [height (in)]<sup>2</sup> x 703. Calculate BMI by dividing weight in pounds (lbs) by height in inches (in) squared and multiplying by a conversion factor of 703.

<sup>20</sup> Glendening PN, Hearne SA, Segal LM, Juliano C, and Earls MJ. "F as in Fat: How Obesity Policies are Failing in America 2005." Available online at <http://healthyamericans.org/reports/obesity2005>.

<sup>21</sup> Department of State Health Services Center for Health Statistics. "Screen Time Use among Texas Adults." Texas Behavioral Risk Factor Surveillance System, 2004.

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- 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 3,382 motor vehicle fatalities in Texas in 2008, 1,463 (43 percent) were alcohol-related.
- Alcohol continues to be the most widely used controlled substance among secondary school students in Texas. In 2008, 63 percent of these students reported they had used alcohol, while 30 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 estimated to be \$9.5 billion.
- Approximately 45 percent of secondary school students reported that they were not drug-free from all substances, including alcohol, during the 2008 school year.
- In 2008, 28 percent of all adults served in the Texas public mental health system were diagnosed with a co-occurring substance abuse disorder.

## **3.2 Recent State and Federal Policy Direction**

This discussion highlights the most significant recent policy direction for the HHS System as a whole. More agency-specific legislation passed by the 81<sup>st</sup> Legislature is referenced in each agency's discussion of challenges, opportunities, trends, and initiatives.

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

As Medicaid spending continues to grow, state policy makers have directed HHSC to pursue multiple efforts to contain Medicaid spending. For example, HHSC's Rider 59 in the 2010-11 General Appropriations Act (S.B. 1, 81<sup>st</sup> Legislature, Regular Session, 2009) reduces HHSC's appropriation by \$107 million in general revenue based on development of new Medicaid cost containment initiatives, such as managed care savings, increases in third party recoveries, and greater utilization review of specific services. Additional state policy guidance provided through instructions to reduce general revenue spending across all agencies for the 2010-11 and 2012-13 biennia will continue the pressure to develop new initiatives to contain Medicaid spending.

While recent efforts to contain Medicaid costs have produced positive results in areas such as managed care, hospital reimbursement, prescription drug purchasing, and third party recovery, the demand for Medicaid services continues to rise, increasing overall Medicaid costs to the State. HHSC will continue this focus on Medicaid cost containment efforts in the future. With the fiscal outlook for the 2012-13 biennium indicating severe budget challenges facing the State, Medicaid cost containment efforts are expected to receive even greater emphasis in the next biennium.

### **3.2.2 Federal Health Care Reform**

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590), and he signed the Health Care and Education Reconciliation Act of 2010 (H.R. 4872) into law on March 30, 2010. Together, the laws make comprehensive health care reforms that are intended to increase access to health care, provide insurance protections, and improve quality of care.

The law makes extensive changes to both public and private insurance plans and practices. The law:

- Includes a mandate for most individuals to have health insurance
- Expands Medicaid coverage of certain populations to 133 percent of the Federal Poverty Level;
- Establishes state-based insurance exchanges for individuals and small employers;
- Requires streamlined eligibility determinations among Medicaid, CHIP, and exchanges;
- Establishes new community-based options and programs; and
- Provides flexibility for states to change provider reimbursement systems.

By 2019, the Congressional Budget Office estimates that the laws will reduce the number of people without health insurance by 32 million people nationally, at a gross cost of \$940 billion for the health-care coverage provisions, with projected net savings to the federal government. The laws are anticipated to reduce the number of uninsured people by mandating coverage, providing subsidies for those under 400 percent of poverty, establishing state-based health insurance exchanges and increasing mandatory eligibility levels for Medicaid. The mandate, increased eligibility for Medicaid, and provision of subsidies with affordable insurance available through exchanges, will significantly affect the operations and budgets of the Texas health and human services agencies. A discussion of this challenge may be found in Chapter 4, Section 4.3.4, Evaluating Impact of Federal Health Care Reform.

### 3.2.3 American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (ARRA) provided a temporary increase—through December 2010—in the Federal Medical Assistance Percentage (FMAP), which is used in determining the amount of federal matching funds for the Medicaid program. Prior to the passage of ARRA, for every dollar spent on Medicaid benefits, the federal government paid almost 60 cents (59.44 percent). The federal formula used to calculate the increase in FMAP provides a hold-harmless rate, an across-the-board increase of 6.2 percentage points, and adjustments according to the percentage increase in unemployment in the state. During the ARRA period, and through March of 2010, the rate has varied between 68.76 percent (first quarter of federal fiscal year (FFY) 2009) and 70.94 percent (second quarter of FFY 2010).<sup>22,23</sup>

ARRA also allocated stimulus funds through various categorical funding areas. These funds include:

- the Prevention and Wellness Fund,
- SNAP (administration funds for the program formerly known as food stamps), Child Care and Development Block Grant, and
- IDEA Part C (the Individuals with Disabilities Education Act's early intervention programs for infants and toddlers with disabilities).

### 3.2.4 Children's Health Insurance Program Reauthorization Act of 2009

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was signed into federal law on February 4, 2009 (Public Law 111-3). CHIPRA reauthorizes CHIP and appropriates federal CHIP funding through FFY 2013. CHIPRA provides states with two years, instead of three years, to spend their federal allotments, and it provides states with new federal requirements and options for state CHIP and Medicaid programs. It also requires Texas to:

- Verify citizenship for CHIP,
- Provide certain dental coverage in CHIP,
- Ensure that CHIP mental health and substance abuse disorder benefits comply with the Mental Health Parity and Addiction Equity Act of 2008,
- Apply certain Medicaid managed care safeguards and quality standards to CHIP, and
- Apply to CHIP the Medicaid prospective payment system for federally qualified health centers and rural health clinics.

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<sup>22</sup> Centers for Medicare & Medicaid Services (<https://www.cms.gov/smdl/downloads/SMD10004.pdf>).

<sup>23</sup> Federal Register /Vol. 74, No. 75 /Tuesday, April 21, 2009 /Notices, (<http://edocket.access.gpo.gov/2009/pdf/E9-9095.pdf>).

In addition, CHIPRA allows Texas to receive federal funding for CHIP coverage of qualified alien children and/or pregnant women who have been in the U.S. for fewer than 5 years.

HHSC staff continues to advance initiatives promulgated through this federal legislation. Effective January 1, 2010, HHSC verifies the citizenship of all CHIP applicants and is working on a State Plan Amendment for CMS approval that will address required changes to the CHIP dental program. The projected implementation date for changes is February 1, 2011. More information about CHIP is available in Appendix F, under HHSC Goal 3: Children's Health Insurance Program.

### **3.2.5 Health Information Technology**

The Legislature directed HHSC to develop a Medicaid-based health information exchange (HIE) system to support improved quality of care by giving providers more and better information about their Medicaid patients.

At the federal level, significant new health information technology (HIT) policy was established through ARRA, including:

- Authorization and funding for a program to provide incentives to Medicaid providers who adopt and make meaningful use of electronic health record (EHR) systems;
- Funding to establish a program to provide funds for states to plan for and implement statewide HIE systems;
- Several other new federal HIT programs that support EHR adoption and HIE use but do not have an explicit role for the state; and
- New amendments to the privacy provisions of Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191).

House Bill (H.B.) 1218, 81<sup>st</sup> Legislature, Regular Session, 2009, establishes pilot programs and projects for development of a Medicaid HER system and the exchange of health information between HHSC and certain health-care entities and facilities. The legislation also establishes a Health Information Exchange Advisory Council. More information about HIT initiatives may be found in Chapter 4, Section 4.4.3, Improving Data Quality and Use.

### **3.2.6 Task Force for Children with Special Needs**

Senate Bill (S.B.) 1824, 81<sup>st</sup> Legislature, Regular Session, 2009, created the Task Force for Children with Special Needs. The task force is composed of legislators, agency leaders, and other stakeholders to develop a five-year strategic plan to

improve the coordination, quality, and efficiency of services delivered to children with chronic illnesses, intellectual and/or developmental disabilities, and/or mental illness. This task force is described more fully in Chapter 4, Section 4.5.6, Task Force for Children with Special Needs.

### **3.2.7 Council on Children and Families**

S.B. 1646, 81<sup>st</sup> Legislature, Regular Session, 2009, created the Council on Children and Families, composed of agency chief executive officers or designees and other stakeholders to coordinate the state's health, education, and human services systems for children and their families, and to prioritize and mobilize resources for children. This council is described more fully in Chapter 4, Section 4.5.7, Council on Children and Families.

### **3.2.8 Autism Resource Center**

H.B. 1574, 81<sup>st</sup> Legislature, Regular Session, 2009, created the Texas Autism Research & Resource Center (TARRC), to coordinate resources for individuals with autism spectrum disorder (ASD) and their families. Once in place, TARRC will:

- Provide information about ASD and related research,
- Conduct training and development activities for persons who interact with individuals with ASD in the course of their employment,
- Coordinate with local entities that provide services to individuals with ASD, and
- Provide support for families.

This effort is described more fully in Chapter 4, in Section 4.5.11, "Texas Autism Research and Resource Center."



# Chapter 4

## Health and Human Services Commission

### External/Internal Assessment

#### 4.1 Overview

The Health and Human Services Commission (HHSC) was created in 1991 by the 72<sup>nd</sup> 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, 78<sup>th</sup> 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 assumed operational responsibility for several large programs, including:

- Medicaid,
- The Children's Health Insurance Program (CHIP),
- The Supplemental Nutrition Assistance Program (SNAP), and
- Temporary Assistance for Needy Families (TANF).

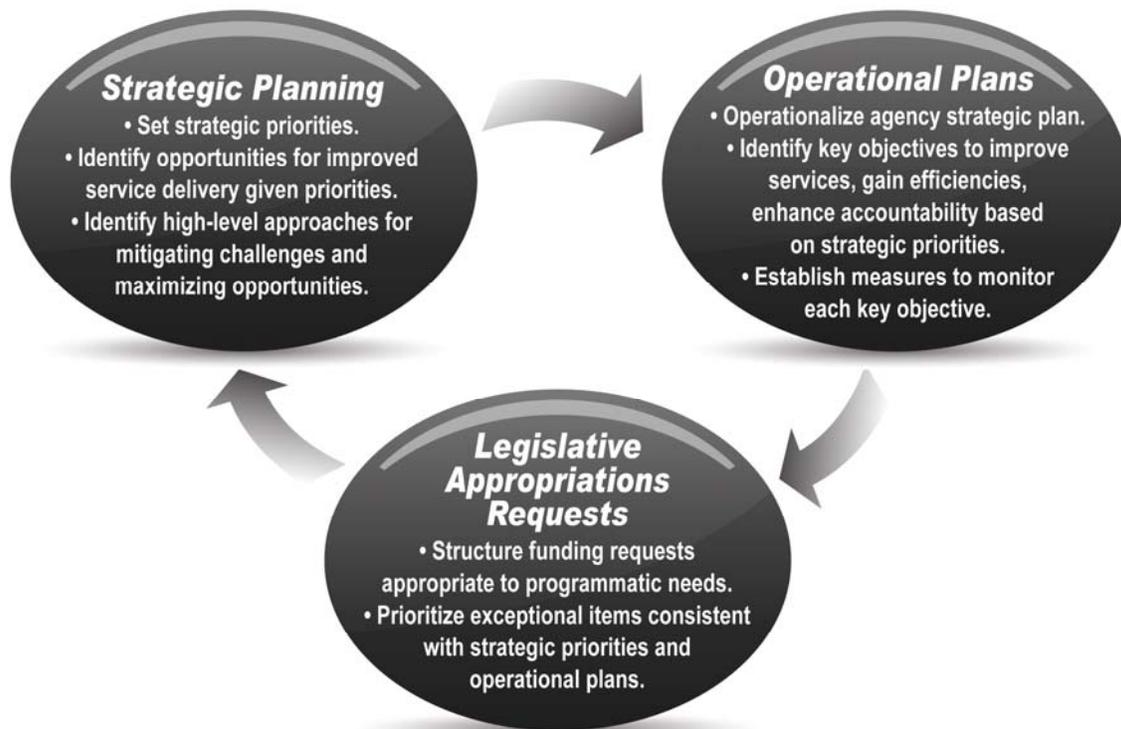
To ensure the HHS agencies are systematically benchmarking strategic planning against operational performance and measurable outcomes, two new planning and accountability tools have been instituted to communicate critical information about agency management and performance to the Executive Commissioner:

- An Executive Management Briefing Process, and
- Operational Planning.

The enterprise-wide quarterly Executive Management Briefing Process, which is coupled with quarterly budget reviews, ensures the Executive Commissioner achieves health and human services oversight and programmatic responsibilities by systematically benchmarking agency performance using information and data contained within the executive management briefs, and it ensures agencies are strategically linking strategic planning, operational planning, and the legislative appropriations development process.

**Figure 4.1**  
**Health and Human Services Planning Cycle**

**GOAL: FORWARD-THINKING STRATEGIC DIRECTION FOR THE HEALTH AND HUMAN SERVICES SYSTEM**



**Figure 4.1: Health and Human Services Commission, Office of Special Counsel for Policy.**

Agency commissioners and HHSC deputy executive commissioners are responsible for developing and implementing a fiscal year operational plan. The operational plan identifies strategies and clearly defined activities that operationalize the strategic plan. Operational plans address key challenges and opportunities identified in the strategic plan, which include the following:

- Prospective and goal-oriented solutions to improve service delivery, achieve efficiencies, or enhance accountability;
- Concrete action steps for addressing ongoing and/or future challenges; and
- Operational milestones and/or measures against which to assess progress.

The linkage between the strategic plan and agency operational plans is essential to ensuring the HHS Enterprise is coordinated in achieving the enterprise-wide strategic priorities. The first agency operational plan submission will occur in August 2010.

By strategically linking the strategic planning process, operational planning, and legislative appropriations request development (See Figure 4.1.), and proactively identifying and communicating critical information through the Executive Management Briefing Process, the HHS enterprise will be well positioned to navigate the opportunities and challenges that will arise in the days ahead.

The material in this chapter is arranged as follows:

- Mission,
- External Assessment: Challenges and Opportunities, and Planned Actions,
- Internal Assessment,
- Cross-Agency Coordination and Planning Initiatives, and
- HHSC Initiatives.

Appendix F includes a description of the agency target populations and service descriptions.

## 4.2 Mission

The mission of HHSC is to maintain and improve the health and human services system in Texas, and to administer its programs in accordance with the highest standards of customer service and accountability for the effective use funds.

## 4.3 External Assessment: Challenges and Opportunities, and Planned Actions

### 4.3.1 Ensuring Quality, Outcomes, and Cost-Effectiveness

There is increasing emphasis, particularly in the Medicaid program, on improving the quality of services and realizing positive health outcomes. Traditionally, providers have been paid for each procedure performed, without rewards for quality of care or health outcomes for the patient. This approach has resulted in ever-increasing costs. For several years national experts as well as Texas policy leaders, and HHSC leaders and specialists, have been addressing the challenge to develop new approaches that encourage the goals of ensuring quality, outcomes, and cost-effectiveness in the health-care delivery system.

Strategic Priorities: Improve the health and well-being of Texans.

- Provide an outcome-based, quality-oriented system of care, and
- Develop cost containment strategies for Medicaid, CHIP, and other programs to ensure sustainability of services.

### Discussion

#### ***Managed Care Quality***

Both in Texas and nationally, Medicaid programs have increasingly turned to managed care systems to more effectively deliver services. As of January 2009, the number of Texas Medicaid managed care enrollees was 2,085,821 people, or 65 percent of the states Medicaid population. The Medicaid program evaluates the managed care organizations' (MCOs') delivery of services in several ways, described below.

#### Quality Measurement and Reporting on Managed Care Organizations

Federal law requires state Medicaid programs to contract with external entities to assist the state in evaluating Medicaid managed care beneficiaries' access to timely and quality care and to develop quality improvement strategies when deficiencies are identified.

The External Quality Review Organization (EQRO) for Texas is the Institute for Child Health Policy (ICHP) at the University of Florida. Among its many duties, ICHP produces an annual Quality of Care Report for each of the Medicaid managed care programs in Texas (STAR, STAR+PLUS, CHIP and STAR Health). These reports can be found at <http://www.hhsc.state.tx.us/Medicaid/other.asp>.

The annual reports provide results of the quality of care for each managed care organization using:

- Selected Healthcare Effectiveness Data and Information Set (HEDIS) measures,
- Rates of inpatient and emergency department services for ambulatory care sensitive conditions, and
- The Agency for Healthcare Research and Quality Pediatric and Prevention Quality Indicators.

The results allow comparison of findings across managed care organizations in each program.

In the next two years, HHSC and the EQRO also plan to evaluate the quality of home-based long-term care services that are provided through Medicaid managed care, including establishing benchmarks, conducting member surveys, and using focused studies to compare health plans and regions, to identify opportunities for improvement in the provision of long-term services and supports.

#### Performance-Based Capitation Rate and Quality Challenge Award

HHSC uniform contract with MCOs has a provision in which up to one percent of an MCO's capitation can be withheld, if performance measure targets are not met. HHSC's objective is that all MCOs achieve performance levels that enable them to receive the full at-risk amount. However, if an MCO does not achieve those performance levels, HHSC will adjust future monthly capitation payments by an appropriate portion of the one percent at-risk amount. Some of the performance indicators are standard across the managed care programs, such as timely claims processing and network adequacy, while others are program-specific.

If one or more MCOs are unable to earn the full amount of the performance-based at-risk portion of the capitation rate, HHSC reallocates the funds through each managed care program's Quality Challenge Award. HHSC uses these funds to reward MCOs that demonstrate superior clinical quality, service delivery, access to care, and/or member satisfaction. HHSC determines the number of MCOs that will receive Quality Challenge Award funds annually based on the amount of the funds to be reallocated.

#### ***Other Quality-Focused Initiatives***

In addition to the quality activities related to managed care organizations, HHSC has a number of initiatives implemented and in progress that focus on improving quality in Medicaid. These include the following programs.

#### Texas Nurse-Family Partnership

The Texas Nurse-Family Partnership (TNFP) is based on a national evidence-based model that has proven results in improving prenatal and maternal health and social

outcomes. Under this program, specially trained registered nurses regularly visit the homes of participating first-time mothers. The nurses provide support, education, and counseling on health, parenting, developmental issues, and life skills. As of December 31, 2009, the TNFP program had 11 sites with 1,289 active clients, and the caseload is expected to reach 2,000 clients in state fiscal year (FY) 2011.

#### Medicaid Enhanced Care Program

This Medicaid disease management (DM) program, known as the Medicaid Enhanced Care Program, has been in place since late 2004. DM is a system of coordinated health-care interventions and communications for populations with conditions in which patient self-care efforts are significant. The goal of DM is to improve the client's health status and quality of life by providing care management resources and education that enable the client to better self-manage a chronic condition. The Enhanced Care Program provides DM services for fee-for-service and Primary Care Case Management (PCCM) clients with specified disease conditions. The program promotes adherence to the local provider's treatment plans and evidence-based guidelines by providing individualized counseling through face-to-face and telephone interaction with specially trained registered nurses. The managed care organizations (MCOs) also have DM programs for their members.

#### Enhanced Primary Care Case Management

The Enhanced PCCM program offers case management services for high-cost clients or clients who are at risk of having a chronic disease. The service is limited to those clients enrolled in PCCM who do not receive DM services.

#### Health Passport

The Health Passport is a web-based electronic health record (EHR) for the children who participate in nationally-recognized STAR Health, Texas' managed care program for children in foster care. The Health Passport gives caseworkers, foster parents, and medical providers an easily accessible record of high-level medical and administrative information that enhances coordination and continuity of care. The STAR Health program is discussed more extensively in Chapter 2, Section 2.6.1, STAR Health.

#### Frew Strategic Initiatives

HHSC has implemented strategic initiatives in response to the settlement in the *Frew vs. Suehs* agreement, to improve the quality of care to Medicaid recipients younger than age 21. Some of the key initiatives include:

- Promotores(as) Outreach in Emergency Rooms;
- Integrated Pediatric and Mental Health Program;
- First Dental Home;
- Oral Evaluation and Fluoride Varnish in the Medical Home; and
- Health Home Pilots.

For more discussion of the *Frew* strategic initiatives, see Section 4.6.1, Medicaid Initiatives, later in this chapter.

## **Planned Actions**

In addition to the work already in place to pursue quality and cost-effectiveness goals, the Medicaid program is pursuing the following initiatives to make further progress in this effort.

### ***Texas Health Management Program***

HHSC plans to implement the Texas Health Management Program in November 2010 to replace the Medicaid Enhanced Care program and the PCCM disease management program. The program will identify and engage clients with high-cost utilizations that can be reduced by improved management of their condition(s) and clients who are at risk of becoming unstable or developing a serious chronic condition(s). The program will:

- Help clients with self-managing their health condition(s);
- Work with providers to encourage patient self-management and clinically evidence-based interventions; and
- Reduce inappropriate or duplicate costs to the state.

This program will also include a diabetes self-management training program as required by H.B. 1990, 81st Legislature, Regular Session, 2009.

### ***Medicaid Child Obesity Prevention Pilot***

Senate Bill (S.B.) 870, 81<sup>st</sup> Legislative Session, Regular Session, 2009, directs HHSC and DSHS to establish and implement an Obesity Prevention Pilot Program to:

- Decrease the rate of obesity,
- Improve nutritional choices and increase physical activity levels, and
- Achieve long-term reductions in program costs incurred by the state as a result of obesity.

HHSC and DSHS are currently working to develop the pilot, with a targeted implementation date of November 1, 2010. The following preliminary decisions have been made regarding the pilot.

- The pilot will be implemented through Medicaid STAR MCOs in the Travis Service Area.
- The program will be available to children who:
  - Are enrolled in Medicaid,
  - Are ages six through eleven,
  - Have not yet begun puberty, and

- Are overweight or obese.
- Eligible children will enroll in the program on a voluntary basis. They will receive pilot benefits for a six-month period, and the MCOs and the state will complete a post-treatment follow-up assessment six months after the active enrollment period ends.

### ***Quality-Based Payments***

HHSC is developing quality-based payment initiatives that improve the quality of care for Medicaid/CHIP enrollees while reducing total program expenditures. Quality-based payments are alternatives to traditional fee-for-service payments and are based on best practices, outcomes, and efficiency, but ensure high-quality, effective health-care services. The Office of Health Services is taking the lead to establish a Quality-Based Payment Workgroup, which will include providers, to help evaluate quality-based payment issues for Medicaid and CHIP.

Quality-based payment models may include bundling of hospital and physician payments for certain services, sharing in generated savings, and encouraging health homes and advanced primary care. For example, under the Medicare Acute Care Episode Demonstration program, Medicare makes a single payment for hospital and physician services for certain cardiac and orthopedic inpatient surgical services. If the demonstration saves money and if certain quality standards are met (e.g. related to post-surgery infection rates, mortality rates, and hospital readmission rates), the participating physicians share in the savings achieved.

### ***Managed Care for Children with Disabilities***

Consistent with direction for Medicaid cost savings, given in HHSC's Rider 59 in the 2010-11 General Appropriations Act (GAA) (S.B. 1, 81st Legislature, Regular Session, 2009), HHSC is working to develop a managed care program for children with disabilities that will improve the coordination of acute care for existing Medicaid recipients. This program also satisfies the requirement in Section 4 of S.B. 10, 80<sup>th</sup> Legislature, Regular Session, 2007, that HHSC develop a tailored benefit package that is customized to meet the health-care needs of Medicaid recipients who are children with special health-care needs.

### ***Health Information Technology Initiatives***

Information on HHSC health information technology (HIT) initiatives, including the Medicaid Eligibility and Health Information System, Medicaid provider electronic health record incentive payments, and e-prescribing, is included in Section 4.4.3, Improving Data Quality and Use, later in this chapter. One of the key goals of these initiatives is to improve the quality of care for Medicaid recipients.

### ***Medicaid Information Technology Architecture***

As the agency updates its Medicaid information system, it is integrating a Centers for Medicare and Medicaid Services (CMS) initiative called Medicaid Information Technology Architecture (MITA). This initiative will transform Medicaid from a claims payment system to a health outcome focus, and it will promote the use of standards to make Medicaid more interoperable across all 50 states. States are required to produce a five- to ten-year roadmap of targeted business processes improvements that will lead to improved health outcomes.

### ***Preventable Adverse Events***

S.B. 203, 81<sup>st</sup> Legislature, Regular Session, 2009, directs HHSC to adopt rules regarding reimbursement denials or reductions of payment for preventable adverse events. The bill requires that Texas Medicaid impose the same reimbursement denials or reductions for preventable adverse events as the federal Medicare program imposes for the same types of health-care associated adverse conditions and the same types of health-care providers and facilities under policies adopted by the federal CMS. The bill allows HHSC to impose payment denials/reductions for other adverse events only after consultation with the state advisory committee on health care quality. The bill requires that HHSC implement payment reductions associated with adverse events by September 1, 2010.

### ***Potentially Preventable Readmissions***

Consistent with H.B. 1218, 81<sup>st</sup> Legislature, Regular Session, 2009, HHSC is developing rules and business processes to support identification and reporting of potentially preventable readmissions (PPR). Effective January 2011, HHSC plans to apply PPR analytics to Medicaid-paid hospital claims. The analytics will establish state- and hospital-specific PPR rates by disease condition and other variables. The information will be provided to hospitals and, as required by H.B. 1218, hospitals will be required to make this data available to their providers.

## **4.3.2 Managing Increasing Medicaid Costs**

For the last several years, Medicaid expenditures have been driven primarily by two factors: rising caseloads and rising cost of care. Additional cost drivers for the next several years will include a rising acuity of many Medicaid clients, including aging baby-boomers and new clients added by national health care reform beginning in 2014.

In FY 2009, caseloads reached 3 million, which is an almost 4 percent growth trend after three years of growth rates below 2 percent a year. Medicaid costs are the primary budget driver for HHSC, with client services costs in 2010 expected to be just under \$16 billion in federal and state funds. Medicaid acute care caseload is the primary cost-driver for Medicaid client services. Also pushing on costs is the change in “case-mix,” which is a term that refers to the mix of high, medium and low cost

illness and medical need. Two groups with high costs—fragile newborns and patients with disability-related medical needs—are growing faster than lower cost clients.

National health care reform enacted in early 2010 is expected to add approximately two million Texans to the Medicaid program beginning in 2014.

The challenge is to keep the cost of care as low as possible, meet quality standards, and ensure enough physicians, hospitals, and other providers to treat the growing Medicaid population.

Strategic Priorities: Improve the health and well-being of Texans.

- Develop cost containment strategies for Medicaid, CHIP, and other programs to ensure sustainability of services.

## **Discussion**

For almost two decades, the state's primary tool for lowering, or managing, costs for Medicaid services has been the use of Managed Care Organizations (MCO) to replace fee-for-service Medicaid payment systems. CHIP services are also delivered through MCOs. Acute care Medicaid is now delivered through MCOs in all urban areas of the state except South Texas. As of January 2009, the number of Medicaid managed care enrollees was 2,085,821, or 65 percent of the state's Medicaid population.

In addition to improving the quality of care, another goal of using a managed care model to deliver care is that the capitated payment gives MCOs an incentive to ensure patients are treated in the most cost efficient manner. HHSC continually monitors whether or not the MCOs are succeeding in this endeavor. Savings due to switching from a fee-for-service model to an MCO system have been particularly good in the first few years of the change. For example, Medicaid clients learn how to use a "medical home," primary care coordinated by a physician, rather than going to an emergency room each time health care is needed. Accordingly, HHSC is reviewing the considerations involved in expanding managed care into additional parts of the state.

HHSC monitors a variety of costs and provider payment factors in an effort to lower and contain costs as much as possible. For example, the Rate Analysis Department researches more than 10,000 medical prices paid for health-care services and reviews how these prices compare to the private sector and Medicaid programs in other states, to identify possible changes to lower expenses. In the case of managed care, the Actuarial Department monitors how the MCOs are spending premiums paid in order to identify any waste. HHSC also studies patterns of procedure utilization by providers to identify areas where changes can be made to encourage the use of less expensive procedures when outcomes can be equally successful.

### ***Billing Coordination System***

S.B. 10, 80<sup>th</sup> Legislature, Regular Session, 2007, requires HHSC to implement an acute care Medicaid Billing Coordination System (BCS) for the fee-for-service and PCCM programs. The legislation required the BCS to identify within 24 hours whether another entity has primary responsibility for paying the claim and submit the claim to an entity the system determines is the primary payer. The legislation also required that all private health insurers allow HHSC access to health insurance enrollment databases. HHSC implemented the BCS for acute care in 2008 and for pharmacy claims in 2009. The BCS has led to substantial cost avoidance for Medicaid.

### ***Women's Health Program***

HHSC continues to evaluate the federal family-planning demonstration project, Women's Health Program (WHP), which has been successful in helping low-income women with family planning needs and related health screenings. For the three-year period from 2007 through 2009, 217,377 Texas women enrolled in WHP.

HHSC estimates that, after paying the costs associated with the program, the WHP services provided in 2008 saved about \$92.7 million during that same year (including both state and federal funds) in Medicaid costs associated with births, infant care, and closely spaced pregnancies. The amount of the savings is based on the methodology prescribed by CMS.

### **Planned Actions**

Planned HHSC efforts for managing increasing costs in the Medicaid program are described below.

### ***National Health Care Reform***

The national health care reform legislation allows for a number of opportunities to change how Medicaid programs are funded, and for several pilot projects to test potential savings. Examples of possible pilots or program changes are listed below.

- Beginning in 2010, states can include drugs in managed care plan benefits and not lose access to federal pharmacy rebates. HHSC is studying the potential savings by including drugs in MCO benefits.
- Demonstration pilot (to begin in 2012) to use bundled payments for episodes of care that include hospitalizations.
- Pilot to allow global capitated, bundled payments for safety net hospital systems to evaluate changes in health-care spending and outcomes.
- Pilot to allow sharing of cost savings with pediatric medical providers organized as accountable care organizations.
- Pilot to place persons with chronic mental health problems into health homes to attempt to lower the use of emergency room care for these enrollees.

- Pilot that would fund up to eight states in a demonstration project to expand the number of emergency inpatient psychiatric care beds. The goal is to see if this could cut down on the use of traditional emergency rooms and reduce costs.
- Federal funding is also available for programs designed to encourage enrollees to improve their own health status through improved lifestyles.

### ***Rider 59 Cost Savings***

HHSC's Rider 59 in the 2010-11 GAA directs HHSC to reduce Medicaid spending by \$107.1 million in general revenue for the 2010-11 biennium. HHSC is in the process of implementing cost-saving changes in how services are reimbursed, with the goal of reaching the \$107.1 million savings target by the end of the biennium. Among the changes are:

- Decreases in the percent of profits MCOs can maintain each year,
- Accelerated use of medical transportation brokers,
- A reduction in administrative fees allowed for MCOs,
- Reduced use of ultrasounds to follow best practice guidelines,
- Requirement for prior authorization for high-cost imaging services, and
- Improved management of maternity care services to reduce over-utilization of high-cost neo-natal intensive care units.

### ***Drug Utilization Review***

The Texas Medicaid Vendor Drug Program has administered the Drug Utilization Review (DUR) Program since it was established in 1992. The goal of the DUR Program is to promote the appropriate use of drug therapy and to reduce Medicaid drug costs.

HHSC's Rider 49 in the 2010-11 GAA directs HHSC to develop and submit a report on the strategies implemented by the agency after September 1, 2009, to strengthen the Texas Medicaid DUR Program. That report was submitted in December 2009. The rider also directs HHSC to develop a follow-up report, due in December 2010, to describe realized cost savings, continued or additional strategies to strengthen the DUR Program, and anticipated cost savings for FY 2011.

## **4.3.3 Improving Eligibility Processes**

Recent growth in the number of applicants and participants in the SNAP, Medicaid, and TANF programs has placed considerable stress on the eligibility system. HHSC is continuing to take action to improve performance in meeting federal standards for timely issuance of benefits and to ensure that benefit levels are accurate, based on family size, income, or other applicable criteria. Progress is already evident: by May 2010, HHSC processed almost 90 percent of SNAP cases on time, compared to 59

percent in October 2009. During the same time period, the backlog, which had been 42,000 past-due cases in October 2009, was eliminated.

Strategic Priority: Deliver the highest quality of customer service.

- Provide benefits accurately and on time; and
- Improve agency business practices to create a more coordinated, cost-effective, and customer-friendly service delivery system.

Strategic Priority: Strengthen and support the health and human services workforce.

- Recruit high-quality staff;
- Increase retention by providing opportunities for continued learning and career advancement;
- Recognize and reward employee performance; and
- Encourage employees to work together across agencies to achieve common goals.

## **Discussion**

HHSC was confronted with considerable increases in applications for assistance during FY 2009, and performance and accuracy suffered as a result. In response, HHSC has implemented a number of strategies for improvement in these areas. For example, additional staff has been hired to assist with the increasing caseloads, and training improvements in case documentation requirements and income calculations have been implemented. As of May 2010, the agency had 850 more eligibility workers than in September 2009, representing a 10 percent increase in the eligibility workforce.

HHSC's Office of Eligibility Services (OES) continues to be challenged in filling and retaining qualified clerks and advisors. Although OES works diligently in recruiting, interviewing and filling jobs to reduce the number of vacant positions, HHS regions still face significant difficulties in retaining staff. The annualized OES staff turnover for FY 2010 is projected to be greater than 15 percent. Moreover, while the number of individuals applying for available OES positions appears satisfactory, the experience, knowledge and skills of many of the applicants do not always ensure a good job match. To promote retention of experienced supervisory staff, a new upgrade schedule is now in place for eligibility supervisors. In addition to improving staff support, HHSC is also working on policy changes to ensure that HHSC policies support accuracy and timeliness improvements in the eligibility processes.

## **Planned Actions**

### ***Staffing***

- To assist the agency in keeping up with the increasing workload, HHSC is filling the 250 additional staff positions approved by the Legislative Budget Board (LBB) in FY 2010 to process SNAP, TANF, and Medicaid cases.

- OES Regional Directors will continue efforts to ensure that vacancy rates do not exceed two percent and to build a pool of viable job candidates.
- Assistance from other agency staff, including Human Resources and staff from the Office of Family Services (OFS), will continue to be deployed to regions with higher employee vacancy rates to assist them with screening and interviewing activities.
- HHSC has contracted with a hiring consultant to work with the Dallas and Houston regions to conduct assessments on job candidates that will assist with hiring better qualified staff for the challenging work environment.

### ***Retention***

- OES management staff is currently developing new criteria for performance-based merit awards. Scheduled to be implemented in July 2010, this system will reward units and regions performing at a high level after the new automation roll-out, and focuses on team work and quality customer service.
- OES directors and management staff continue to implement employee recognition and motivational initiatives.
- To support new staff, training environments have been established that give better access to peers and mentors to help in learning job functions.

### ***Policy Changes***

HHSC continues to work closely with federal partners in the Food and Nutrition Service (FNS) and CMS to make changes to eligibility policy to enhance eligibility determination processes and performance. In addition, HHSC making the following improvements:

- Revising the Medicaid Eligibility for the Elderly and People with Disabilities (MEPD) Handbook and state processes to delete legacy process and practice information and to add information to support roll out and operations in a TIERS-only environment,
- Consolidating policy, process, and casework reference guides on the OFS/MEPD Website so that information needed to support eligibility determination is easy to find, and
- Coordinating eligibility determination processes with DADS and DSHS for people accessing Medicaid-funded long term services and supports.

## **4.3.4 Evaluating Impact of Federal Health Care Reform**

HHSC is assessing the federal health care reform legislation to determine its impact on the current HHS system and to successfully integrate the required changes into eligibility determination, automation, and all other relevant program operations.

HHSC will seek policy direction from the Governor and Legislature in several key areas.

Strategic Priority: Improve the health and well-being of Texans.

- Emphasize health promotion, primary care, disease prevention, and early intervention for improved long-term health outcomes.

**Discussion**

Under federal health care reform, more Texans will likely have access to health-care coverage, primarily due to the mandated Medicaid expansion, which increases Medicaid eligibility to 133 percent of the federal poverty level, for non-pregnant individuals younger than age 65, which begins in 2014. Also beginning January 2014, states must provide Medicaid to individuals younger than age 26 who were formerly in foster care and on Medicaid.

The federal changes will also grow some existing state-run programs and will provide alternative coverage for clients who currently receive health-care services through various state programs. HHSC will continually evaluate the impact to mental and public health, substance abuse, and regulatory programs and services.

To help cover the costs of the changes, the federal legislation increases federal financial participation levels for CHIP and Medicaid. In Texas, the increased federal financial participation for newly eligible individuals in Medicaid is as follows:

- 100 percent in 2014 through 2016,
- 95 percent in 2017,
- 94 percent in 2018,
- 93 percent in 2019, and
- 90 percent in 2020.

For CHIP, the federal financial participation increases by 23 percentage points from October 2015 through September 2019. Despite the increases in federal financial participation, HHSC estimates significant general revenue costs due to increased caseloads.

The federal reform requires reductions in disproportionate share hospital (DSH) allotments, which are federal funds used to compensate hospitals that treat a significant share of people who cannot pay fully for their own care. Starting in 2014, Texas and other states will receive reductions in their DSH payments based on a methodology that takes into account the percentage of people in each state who are uninsured and how well each state targets its DSH payments to hospitals with a large proportion of uncompensated care. Also, state prescription drug rebates per person are projected to decrease under the law.

The new federal law also provides states with optional programs for acute care, long-term care, and service delivery systems.

- A voluntary, public insurance program for long-term care provides a cash benefit for the purchase of community-based supports and services to adults with qualifying functional impairments.
- A Community First Choice option provides a state plan option for community care with increased federal financial participation for providing community-based attendant supports and services to individuals with disabilities who qualify for an institutional level of care.

In addition to eligibility criteria reform, states are required to streamline and simplify the enrollment process itself to achieve a “no wrong door” approach. The Medicaid and CHIP eligibility processes must be coordinated with the process to determine eligibility for subsidies for purchasing insurance through the new insurance exchange. State-based exchanges, which must be administered by government agencies or non-profits identified by each state, are required to provide individuals and small businesses access to affordable qualified coverage. The streamlined application program must achieve the following:

- Allow individuals to enroll in Medicaid through a website;
- Enroll eligible individuals as identified by the exchange into Medicaid or CHIP, without any further determination by the state;
- Ensure that individuals who are ineligible for Medicaid or CHIP are screened for exchange benefits and premium assistance, and are enrolled without submitting a separate application;
- Ensure that Medicaid, CHIP, and the exchange use a secure electronic interface that allows for eligibility determinations and enrollment in each program; and
- Conduct outreach to enroll underserved populations in Medicaid and CHIP.

These changes will significantly impact the budgets and operations of the HHS agencies and other state agencies, requiring extensive coordination among Medicaid, CHIP, and the new insurance exchange. HHSC will continue to analyze the mandated changes to identify options to cost-effectively implement federal requirements and opportunities to improve Medicaid and CHIP enrollment for clients.

### **Planned Actions**

- HHSC is developing an effective and timely process and organizational structure to evaluate and implement, as appropriate, within the HHS enterprise, the program and system changes that are required by federal law. The timeframe will be established as specific impacts of the law are better understood and legislative direction is received.

- HHSC will use statutory changes and options to improve cost-effective outcomes, by restructuring existing Medicaid delivery systems, improving rate-development methodologies, and implementing quality-based payment structures through the Medicaid and CHIP programs. The timeframe will be established as specific impacts of the law are better understood and legislative direction is received.

### **4.3.5 Renewing the Focus on Customer Service and Community Involvement**

Providing high-quality customer service in the environment of significantly increased demand for services has been a challenge for HHSC over the past few years. HHSC's Executive Commissioner has placed renewed focus on providing quality customer service while efforts are in progress to address major challenges related to staffing, automated systems, and business processes. At the same time, key community partners have been called upon to assist the agency in improving customer service and ensuring effective community involvement the area of eligibility determination and other agency programs and services.

Strategic Priority: Deliver the highest quality of customer service.

- Provide benefits accurately and on time; and
- Improve agency business practices to create a more coordinated, cost-effective, and customer-friendly service delivery system;

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with families, stakeholders, community organizations, providers, and others in the public to address service delivery issues and ensure customers receive timely, appropriate services;
- Work closely with local food banks and other organizations to assist people in applying for nutrition, medical, and cash assistance, and other critical service needs; and
- Continue to develop and improve volunteer programs to support service delivery.

### **Discussion**

Particularly in the area of HHSC's determination of eligibility for people who are applying for the agency's services, the recent economic downturn has exacerbated a system that was already under stress.

- The system is in the process of converting from a 1970's-era computer system to a web-based format that will eventually be available to clients online. Rolling out the new system requires employees to take time for

training, and that takes time away from their work. Section 4.4.2, TIERS Expansion, found later in this chapter, contains more information about this issue.

- Other office infrastructure has aged, or demand has exceeded capacity, and the space and/or equipment is no longer fully functional, as noted by the State Auditor in the report requested by the Executive Commissioner.
- During the past few years, policy changes have also been made, requiring process changes and training for employees.

While these changes, once completed, will ultimately improve the agency's ability to better serve customers, the transition process continues to present significant challenges, which are being addressed on several fronts, as discussed below.

## **Planned Actions**

### ***Improved Business Processes***

At the HHSC Executive Commissioner's request, the State Auditor's Office (SAO) conducted an audit of the SNAP program's business process to identify areas for improvement. HHSC is incorporating the SAO's recommendations, along with a SNAP corrective action plan and findings from internal reviews, into a comprehensive service improvement plan. The plan includes immediate and long-term initiatives that will be implemented to ensure the eligibility system works more efficiently in the future, delivers benefits on time, and provides better customer service.

For the federal SNAP and Medicaid programs, the agency will continue to simplify and streamline the processes for determining eligibility, while maintaining compliance with state and federal laws, and deterring fraud and abuse.

### ***Increased Resources***

HHSC received approval from the LBB to hire 250 additional employees to assist with eligibility services. The agency continues to address employee turnover by using a "hire-ahead" policy based on vacancy trends that can be identified and projected into the future.

OES Field Operations developed and distributed revised job postings and interview questions in an effort to identify applicants with skills and abilities that will lead to providing a better quality customer service.

### ***Staff Re-Focusing and Training***

OES is developing a training module on customer service for all levels of OES staff, which will be delivered in summer and fall of 2010. Further, community-based providers will conduct family wellness relationship skills training to eligibility staff to

improve customer service with clients and relationship skills with co-workers and family.

In late 2009, OES began moving toward a service delivery model that includes a “same day – next day” concept where applicants are seen within a day of their application date whenever possible. Since the inception of this plan, the time it takes to schedule a client interview has decreased in every region. The service delivery model is being modified to further reduce the number of times a customer has to visit an eligibility office in order to complete the application process. Larger offices will place a “duty worker” at the front desk or in the lobby to respond to customer inquiries and assist in completing cases.

### ***Collaborative Partnerships***

The agency builds relationships with community partners in a variety of ways to serve clients in the best way possible.

During FY 2010, waivers were obtained from FNS to allow HHSC to fulfill the SNAP interview requirement through the SNAP outreach and application assistance provided by designated community-based organizations. HHSC policy was implemented to enable and support a partnership with the Texas Food Bank Network. This innovative model is already achieving results, and as it continues to show success, it may be expanded to cover more areas.

In service to the TANF program, the agency will continue to

- Develop efficient referral and coordination processes with other agencies or community organizations for TANF recipients with barriers to employment, and
- Encourage workforce education and training opportunities.

The agency also contracts or partners with community-based providers and other stakeholders for other services, including:

- Outreach and application assistance for HHSC social service programs, with a focus on CHIP and Children’s Medicaid;
- Education programs on marriage and relationship skills for parents and new couples;
- Application support and assistance for refugee clients for Refugee Medical Assistance and related SNAP cases; and
- Prevention of family violence through programs or services related to domestic violence fatality reviews, economic stability, legal services, health services, home visitation programs, and community-based primary prevention plans.

An HHSC Task Force on Strengthening Non-profit Capacity is holding public hearings and receiving written comments about how to strengthen non-profit

capacity for providing charitable and social services to Texans in need. The public input, to be taken in the spring and summer of 2010, will be used to help develop recommendations and a report for the Texas Legislature.

## 4.4 Internal Assessment

### 4.4.1 Maintaining and Developing the Workforce

#### Survey of Employee Engagement

Formerly known as the Survey of Organizational Excellence, the Survey of Employee Engagement (SEE) is administered every two years by the University of Texas at Austin Center for Organizational Excellence. This survey assists organizational leadership by providing information about workforce issues that impact the quality of service that is ultimately delivered to all customers.

The survey was completed in March 2010. After reports are received from the Center for Organizational Excellence, the data will be analyzed. HHSC will evaluate SEE information in the context of supporting the agency's strategic priorities and determine whether any of the issues identified should be selected as actions items. Selected action items will be addressed in plans for change. These plans will include baseline information for future surveys.

#### Eligibility Workforce Training

To help new eligibility employees be more successful, the agency has developed and implemented new training programs that are streamlined and accelerated. Training cluster environments were created to provide more support to new staff. The curriculum and its delivery are hands-on, role-based training, which integrates policy and functionality. Web-based training and webinars are utilized when there is a limited amount of information that needs to be conveyed statewide.

#### Retirements

Retirements pose many challenges and opportunities for the HHS system. The aging of the "baby boomers" and their impending retirements will likely have an impact on the HHS workforce. HHSC is reviewing the responses given by retiring employees in their exit surveys to gain insight into the reasons why some tenured staff are choosing to leave the agency. Conversely, the retiring baby boomers create unique opportunities for the HHS workforce to recruit and promote new talent for providing the highest quality services. While the HHS system does provide employment opportunities for those retired employees who wish to resume their employment after the designated period, this practice can inhibit talented staff from

moving into management or other senior positions, which can impact a less-tenured staff member's decision to stay with the system.

This issue can be addressed by formalized succession planning programs, which identify potential leaders so they are trained or mentored in how to become a supervisor, manager, or successful leader. Another opportunity would allow the returning retirees to work with and mentor these less-tenured employees for future supervisory or management opportunities.

### **Systemwide Training / Positive Performance**

In response to a State Auditor's Office 2008 report, the Training and Organizational Development (T&OD) Unit was created to standardize training and evaluation across the HHS Enterprise. To effectively address the audit recommendations, the unit has implemented several programs which include the following:

- Developing and delivering training programs to help supervisors and managers in acquiring the knowledge and skills to better manage job requirements;
- Developing and ensuring ongoing implementation of the curriculum for the online Training Program for Managers; and
- Creating a system to track, update, and report on the required training classes for each agency.

The unit is expanding the use of current technology, such as distance learning capacities, to facilitate greater access to training and reduce travel and other costs. Another T&OD initiative is a train-the-trainer approach, as part of the ProjectONE plan, an enterprise resource planning system which is described on p. 61 of this document.

Future activities of the training unit include:

- Implementation of a supervisor/manager development program and a leadership development program,
- Development of additional online trainings and the means to track and maintain online training, and
- Development and implementation of a plan to help organizational leaders and their groups improve productivity and employee satisfaction.

## **4.4.2 Addressing Infrastructure Needs**

### **Eligibility Office Improvement**

Business and Regional Services is currently assessing office improvement project proposals for regional facilities and exploring funding sources to carry out those projects. Assessment includes identifying and quantifying the needs of each facility,

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working with program leadership to establish priorities, and working with budget staff regarding funding and reporting requirements. Given the likelihood that recommended projects will exceed funding, an overarching priority has been established to focus on those facilities in which HHS will likely remain for the foreseeable future.

### **TIERS Expansion**

The Texas Integrated Eligibility Redesign System (TIERS) is a multi-year technology project that supports the state-of-the-art eligibility determination and managed care enrollment system for HHS programs. TIERS provides a single, integrated, automated system for use in delivering SNAP benefits, cash assistance, children's Medicaid, CHIP, and medical and long-term care services to Texans in need. TIERS supports the state's eligibility system, which offers a menu of options to consumers who seek assistance or services. TIERS also supports the state's efforts to improve customer service, provide a more efficient system for eligibility determination, and enhance fraud protection tools. The TIERS statewide rollout plan is projected to be completed in FY 2011.

HHSC is using a new training program, "TIERS Rollout Training," to support the rollout of the new eligibility system statewide. The agency is conducting Readiness Assessments via on-site reviews approximately 60 days prior to each region's conversion to the new automated system to identify areas that need to be addressed by the region. Staff conducts follow-up reviews approximately 30 days prior to a region's conversion to identify any concerns that would prohibit conversion.

Following each rollout, performance will be closely monitored. Senior management and experienced TIERS workers will be on-site to help address any issues during the conversion. Daily conference calls will be held for the first month following the rollouts. Impact on client services will be measured by monitoring lead time (the number of days between receipt of an application and the first available interview appointment) and timeliness at each office. A comparison of total benefits issued before and after conversion will be conducted to ensure that benefits have been properly issued. Lessons learned from each rollout and staff feedback in the newly converted offices will be used to further improve HHSC's preparation activities for rollout to other regions.

### **Transitioning Data Center Services**

The Texas Department of Information Resources (DIR) executed a contract with a private vendor to provide data center consolidation and operations for multiple state agencies, including all HHS agencies. This contract provides participating agencies data center (mainframe and server operations), disaster recovery, and bulk print and mail services. The contract includes transition of legacy agency data center operations to the service provider, consolidation of these operations to the state data centers, and transformation of services for greater consistency, efficiency, and

value. Until consolidation is completed, all services will be maintained in legacy data centers.

The contract was executed in November 2006 and continues to evolve. The first phase occurred in April 2007, and the transformation continues for agency-operated services, such as email, and transitioning agency staff to the vendor. As recently as December 2009, DIR, in concert with many of the 27 agencies involved, began negotiations for modifications of the master agreement with the vendor. These negotiations will revise the transformation strategy and re-prioritize transformation activities to:

- Improve the state's ability to meet its business needs,
- Speed the migration of servers to the data centers,
- Prioritize servers to minimize lease charges to agencies, and
- Re-prioritize critical applications in the migration to the data centers.

### **ProjectONE**

In response to H.B. 3106, 80<sup>th</sup> Legislature, Regular Session, 2007, the Comptroller of Public Accounts established an Enterprise Resource Planning (ERP) system to create an information system based on a common database and common software tools. This ERP, known as ProjectONE, is designed to allow real-time information to be accessed, shared, and compared easily and immediately across agencies and organizations. Agencies participating in this effort include the five HHS agencies, the Texas Department of Transportation, the Texas Department of Motor Vehicles, and DIR.

ERP includes the administration of the following state agency systems:

- General ledger,
- Accounts payable,
- Accounts receivable,
- Budgeting,
- Inventory,
- Asset management,
- Billing,
- Payroll,
- Projects,
- Grants, and
- Human resources, including administration of performance measures, time spent on tasks, and other personnel and labor issues.

## **Health and Human Services Telecommunications Managed Services**

When the HHS agencies consolidated in 2004, more than 14 different types of telephone systems were deployed throughout HHS offices with no centralized planning or coordination. The average age of HHS phone systems at that time was 11 years, with some as old as 24 years, and many systems were no longer supported by their manufacturers, resulting in longer downtime during system outages. In the 2008-09 biennium, HHSC awarded a five-year contract to AT&T to establish an enterprise-wide approach to telecommunications in an effort to reduce costs, improve services to clients, and improve productivity. Since the contract was awarded in 2009, 76 percent of users have been migrated to the new system. The new telecommunications services system has brought the HHS agencies together under unified processes, reduced administrative burdens on field resources, and improved up-time and availability. Statewide updates of the remaining phone systems are scheduled to be complete by April 2012.

### **4.4.3 Improving Data Quality and Use**

#### **Overview**

The effective use of HHS eligibility, enrollment, claims, and utilization data is critical to agency programs and processes. Quality data are required for:

- Effective program management;
- Planning, research, and evaluation purposes;
- Reporting to state and federal regulatory agencies; and
- Responding to requests for information from public officials, stakeholder organizations, and the public.

Problems with data quality often occur when more than one system is used to perform the same function. For example, there are currently two eligibility systems for Medicaid, SNAP and TANF: the legacy SAVERR system and the newer TIERS system. Based on the way in which the data are converted from one system to the other, data quality problems can exist.

For the Medicaid program, most claims are adjudicated (determined to be paid or denied) in two systems: The Texas Medicaid & Healthcare Partnership (TMHP), which administers all state Medicaid claims, and First Health Services Corporation, which administers state vendor drug claims. However, there are more than 20 systems that adjudicate other types of Medicaid claims. These systems were developed independently from the two systems referenced above, and the data from each must be converted for any cross-system analyses.

Further, the current data systems are transactional systems used to support everyday operations. While some of these systems have reporting components, they are typically unable to produce data in the form needed for reporting to internal and external entities. Thus, considerable staff time and effort are required to convert

the data to a consistent and usable format, and data quality problems often become apparent after the conversion occurs.

Matching data from the Medicaid, SNAP, and TANF eligibility and claims systems with data from other HHS programs is also problematic. When matching is required, the process is again time-consuming and expensive in terms of staff times and computer resources.

HHSC is currently involved in several projects to address these issues. As TIERS is rolled out, an increasing proportion of the total caseload will be processed in TIERS, which will alleviate many of the data conversion issues.

The proposed Enterprise Data Warehouse/Business Intelligence system, described below, has the potential to address a number of data issues, and it would consolidate client eligibility, enrollment, claims and utilization data, which will standardize data from the multiple transactional systems.

### **Enterprise Data Warehouse**

In accordance with HHSC's Rider 46 in the 2010-11 GAA, HHSC is developing an enterprise data warehouse (EDW) for strategic decision-making and the identification of operational improvements to programs and functions within the HHS system. The integration of data across all HHS agencies will be used to:

- Determine how the delivery of health-care services to Texans can be improved,
- Help evaluate program effectiveness,
- Determine more cost-effective means of delivering services,
- Detect fraud and abuse, and
- Aid in the forecasting of the state's human services needs and priorities in the future.

It is anticipated that the solution recommended for implementation will align and complement the goals and objectives of other enterprise initiatives, including the MITA, health information exchanges, and master data management projects. In the context of HHS, master data management is the capability to match or link records accurately across different systems to establish a unified and contextually accurate view of a client and a provider, and establish data governance to ensure the information is reliable and secure. HHSC's vision for an EDW includes:

- Minimizing the labor intensity currently required for enterprise queries and reporting;
- Improving health quality outcomes through use of tools like benchmarking, trend analysis, and predictive modeling;
- Improving the quality of the data used to support and validate decision-making; and

- Reducing data redundancy and enhancing the congruency of reports.

The EDW is currently in its planning phase: a needs assessment, cost benefits analysis, solution alternatives analysis, and a roadmap and detailed requirements for implementation. It is anticipated that planning will be completed in August 2011, with the implementation phase commencing thereafter, pending approval of funding by CMS. The primary focus during the first three to five years of its implementation will be to support Medicaid-related services and functionality. A plan and implementation roadmap for other services, such as TANF and SNAP, will be established thereafter.

### **Obtaining Managed Care Data to Ensure Quality**

Obtaining reliable data on managed care providers and services is an area that has been targeted for improvement and achieved some success, but challenges still remain. Provider information is not always current in the TMHP system, and member information is also difficult to keep current, due to the mobility of members in the population. The following actions are in progress to address these issues:

- Implementing changes to the enrollment and retention of Medicaid providers, which will remove inactive providers and improve information;
- Planning a future modification to address certain errors in categorization for primary care physicians;
- Identifying and correcting inaccurate member information based on existing management reports; and
- Identifying inaccuracies that are not currently addressed by the management reports and escalating for correction.

### **Health Information Technology Initiatives**

There are numerous state and federal health information technology (HIT) initiatives that must be effectively coordinated in order to achieve the goals of improving patient care and producing cost savings in the health-care delivery system.

HIT refers to the exchange of health information in an electronic environment. The goal of HIT is to allow comprehensive management of medical information and its secure exchange between health-care consumers, providers, and payers in an effort to improve the quality of care, prevent medical errors, reduce health-care costs, and increase administrative efficiencies. HIT initiatives include, but are not limited to, EHRs, electronic prescribing, and health information exchange (HIE) systems.

With a new and increasing focus on support of and coordination among HIT initiatives, both internal and external to the enterprise, it will be important for HHSC to develop and maintain an active and explicit focus on HIT promotion and coordination in the coming years.

As described briefly in Chapter 3, Section 3.2.5, Health Information Technology, federal and state policy direction relating to HIT will affect HHSC operations. At the state level, the Legislature directed HHSC to develop a Medicaid-based HIE system to support improved quality of care by giving providers more and better information about their Medicaid patients.

At the federal level, significant new HIT policy was established through the American Recovery and Reinvestment Act (ARRA) of 2009 that includes:

- Creation of a program to provide incentives to Medicaid providers who adopt and make meaningful use of electronic health record systems;
- Funding for states to plan for and implement statewide HIE systems;
- New federal HIT programs that support EHR adoption and HIE use but do not have an explicit role for the state; and
- New amendments to the privacy provisions of HIPAA.

HHSC is working on several different fronts to ensure the coordination and development of effective HIT systems.

### ***Statewide***

#### **Health Information Exchange Plan**

To ensure the coordination of HIT activities, in October 2009 HHSC received a federal grant of \$28.8 million to plan and implement a statewide HIE. HHSC will contract with the Texas Health Services Authority to coordinate the planning effort. HHSC is working with the Governor's Office, the Texas Health Services Authority, and stakeholders to develop the state HIE plan.

### ***Medicaid/CHIP***

#### **Provider Incentive Program**

The American Recovery and Reinvestment Act of 2009 (ARRA) allows states to receive 100 percent federal financial participation for incentive payments to Medicaid providers to purchase, implement, and "meaningfully use" certified EHRs. ARRA designates between \$36 to \$46 billion for EHR incentive payments to Medicaid and Medicare providers. Payments to qualified providers may take place as soon as January 2011.

Before states can begin to make payments to providers, a significant amount of planning and decision-making must take place. CMS approved Texas' Planning Advance Planning Document in November 2009, authorizing up to \$4.3 million all funds (\$3.86 million federal funds based on a 90/10 match rate) for HHSC to plan for the Medicaid provider incentive payments. The majority of the funds in the approved budget are for contractor services.

### Medicaid and CHIP Health Information Exchange System

House Bill 1218, 81<sup>st</sup> Legislature, Regular Session, 2009, directs HHSC to develop an electronic HIE system to improve the quality, safety, and efficiency of health-care services provided under Medicaid and CHIP. The new Medicaid Eligibility and Health Information System (MEHIS), scheduled for implementation by March 2011, will:

- Replace the current paper Medicaid identification form with a permanent plastic card;
- Automate eligibility verification;
- Provide an EHR for all Medicaid clients;
- Introduce e-prescribing functionality; and
- Establish a foundation for future HIE use for improved efficiency, continuity of care, and improved health outcomes.

H.B. 1218 also directs HHSC to establish an advisory committee and a pilot program with regional HIE organizations. The HIE Advisory Committee held its first meeting in February 2010. Implementation of the pilot program began in 2010, and the exchange of data will begin by September 2010. HHSC will provide a preliminary report on the HIE system and pilot to the Legislature by January 1, 2011.

### e-Prescribing

H.B. 1966, 81<sup>st</sup> Legislature, Regular Session, 2009, and HHSC's Rider 51 in the 2010-11 GAA direct HHSC to develop an implementation plan for e-prescribing in Medicaid and CHIP. Medicaid/CHIP staff collaborated with other partner agencies to develop an e-prescribing implementation plan aimed at reducing adverse drug events and costs. Work involved includes the following activities:

- Establishing interfaces with e-prescribing networks, in collaboration with a vendor, to develop a service for prescribers and pharmacists to exchange decision support information and prescriptions for Medicaid and CHIP clients;
- Collaborating with the Medicaid Eligibility staff and MEHIS program to develop a web application by 2011, to allow prescribers to perform e-prescribing for Medicaid clients at no cost to the prescriber; and
- Identifying policy needs to ensure consistent application and increased use.

HHSC published the implementation plan in December 2009 and will provide a report to the Legislature in December 2010.

## 4.5 Cross-Agency Coordination and Planning Initiatives

### 4.5.1 Coordinated Strategic Plan for Health and Human Services

The Coordinated Strategic Plan (CSP), required by Section 531.022 of the Texas Government Code, allows the Enterprise to communicate a unified vision and action steps to achieve strategic priorities, and it serves as the strategic plan for the HHS System. 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 a single document. Chapters 2 and 3 of this document constitute the CSP. 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.

In the planning process, described in Appendix A, HHSC met the requirements for public comment for the CSP. The CSP will be provided to all the required recipients for the CSP in July, prior to the CSP due date of October 1, 2010.

### 4.5.2 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.<sup>1</sup> Figure 4.1 illustrates these designated regions.

The populations of both the Texas-Louisiana and the Texas-Mexico border regions are growing. From 2011 to the year 2015, 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 (6 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 (4 percent) compared to the Texas-Mexico border counties. Thirty-seven or 86 percent of the counties along the Texas-Mexico border have poverty rates that exceed the state average.

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<sup>1</sup> 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.



Approximately 400,000 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, paved roads, electricity, and telephone service. Due to all these factors, access to health services is also a challenge. Today, more than 2,000 Colonias exist in the area located primarily along the state's 1,248 mile border with Mexico.

The HHSC Office of Border Affairs was created to ensure coordination of services and supports for those living in the Texas border regions. The HHS Enterprise agencies have developed an interagency partnership with the HHSC Office of Border Affairs, the Texas A&M University Colonias Program, the Texas Workforce Commission (TWC), local workforce development boards, the Texas Education Agency (TEA), local school districts, and educational service centers. The partnership, which has expanded to include various community-based organizations, faith based organizations, as well as promotora organizations, continues with the Texas-Mexico Border Colonias Initiative, a coordinated outreach effort to enhance conditions supporting good health and self-sufficiency in colonias along the border. The interagency consortium seeks ways to provide colonias residents with better access to state-funded programs.

HHS 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.

### 4.5.3 Psychotropic Medication Monitoring

In September 2004, the release of an Office of Inspector General (OIG) report raised concerns regarding the use of psychotropic medications among Texas children in foster care. Since then, HHSC, DSHS, and DFPS have coordinated efforts to obtain a more detailed assessment of the problem and to assist providers in using psychotropic medication appropriately, both for children in foster care and for all children enrolled in Medicaid.

Work related to children in foster care have included the following efforts.

- **The 2005 release and biennial update of the best practice guidelines—***Psychoactive Medication Utilization Parameters for Foster Children.*
- **Annual analysis of how Medicaid prescribing practices align with these guidelines—**Analysis has revealed that psychoactive prescribing to children in foster care has generally decreased since the release of the guidelines in early 2005, both in terms of the percentage of children in foster care and in the overall number of children receiving medication.
- **Bi-monthly meetings of a Psychotropic Medication Monitoring Group—**With representatives from DFPS, HHSC, DSHS, and the administrator of the

STAR Health Medicaid managed care program for children in foster care, this group reviews monthly monitoring conducted by the administrator and its behavioral health subcontractor. It also oversees an annual report on psychotropic utilization and the biennial review of the parameters.

HHSC, DSHS, and DFPS are coordinating on a study related to the appropriateness and safety of the use of antipsychotic medication among all children enrolled in Medicaid who are younger than age 16. As required by H.B. 2163, 81<sup>st</sup> Legislature, Regular Session, 2009, HHSC will submit a report on this topic to the Legislature by November 1, 2010.

#### **4.5.4 Family-Based Alternatives Project**

This project was established by S.B. 368, 77<sup>th</sup> 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 a 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 by 24 percent, and more than 1,500 children have moved from institutions into families or family-based alternatives.

#### **4.5.5 Coordinated Strategy for Early Childhood Services**

Senate Bill 665, 77<sup>th</sup> 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 the Texas Education Agency, the Texas Workforce Commission, 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, 77<sup>th</sup> 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 with agencies within and outside of 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.

#### **4.5.6 Task Force for Children with Special Needs**

The Task Force for Children with Special Needs was established by S.B. 1824, 81<sup>st</sup> Legislature, Regular Session, 2009, and is overseen by the Governor's Office and administered by HHSC. The Task Force is an 18-member committee comprised of four legislators, key leaders from nine state agencies, three consumers/advocates, and one representative from a local mental health/mental retardation authority. The Task Force includes eight statutorily mandated subcommittees, focusing on: health, mental health, education, juvenile justice, crisis prevention and intervention, transitioning youth, long-term care, and early childhood intervention. By uniting policy makers, agency leaders, disability advocates, consumers, and subject-matter experts, the Task Force is working to establish a joint vision for a system that better serves the needs of this population.

The mission of the Task Force is to create a strategic plan to improve the coordination, quality, and efficiency of services delivered to children with chronic illnesses, intellectual and/or developmental disabilities, and/or mental illness. The strategic plan is due to the Legislature by September 1, 2011, and will provide specific recommendations to be implemented over a five-year period.

#### **4.5.7 Council on Children and Families**

Senate Bill 1646, 81<sup>st</sup> Legislature, Regular Session, 2009, created the Council on Children and Families to coordinate the state's health, education, and human services systems for children and their families, and to prioritize and mobilize resources for children. Members of the Council include the chief executive officers, or designees, of ten state agencies serving children, along with four public members

appointed by the HHSC Executive Commissioner. The Council is administratively attached to HHSC, but is independent in its direction.

The Council is charged with:

- Conducting a biennial review and analysis of each member agency's LAR relating to children's services, resulting in a report (due May 1 in even-numbered years) recommending modifications for the next biennial LARs;
- Investigating opportunities to increase flexible funding for health, education, and human services;
- Identifying methods to remove barriers to coordination at the local level;
- Identifying methods to improve screening, assessment, and early intervention;
- Developing methods to prevent unnecessary parental relinquishment of custody of children;
- Prioritizing assisting children in family settings rather than institutional settings; and
- Making recommendations about family involvement in the provision and planning of health, education, and human services for a child.

A biennial report including recommendations to the Legislature is due on December 1 of even-numbered years.

### **4.5.8 Office of Acquired Brain Injury**

The Office of Acquired Brain Injury (OABI) is the state's primary resource to provide education, awareness, and service referral and coordination to persons with brain injuries, their family members, caregivers, service providers, and others. Clients include veterans and service members returning from Iraq and Afghanistan.

An acquired brain injury (ABI) is an injury that occurs after birth and interferes with the normal function of the brain. It includes traumatic brain injury (TBI), which is the result of a blow or jolt to the head or a penetrating wound, and it also includes non-external traumas such as stroke, heart attack, infection, choking, exposure to toxic substances, brain tumors, near-drowning, or other incidences depriving the brain of oxygen.

An ABI affects cognitive, physical, emotional, and social abilities and may have catastrophic economic impact on the individual and/or family. In infants, children, and youth it may affect brain development and often impairs, temporarily or permanently, their daily living skills, which may affect their ability to live independently.

According to the Brain Injury Association of America, brain injury is the leading cause of death and disability in persons younger than 45 years old, occurring more frequently than breast cancer, AIDS, multiple sclerosis, and spinal cord injury

combined. Populations at highest risk for brain injury are infants and children from birth through 4 years of age, adolescents (predominantly male) 16 to 25 years of age, and adults older than 65 years of age.

Centers for Disease Control and Prevention reports that:

- TBI is a contributing factor to one third of all injury-related deaths in the United States;
- More than 155,000 Texans sustain a brain injury each year, one every four minutes; and
- More than 550,000 Texans are known to be living with a disability due to a brain injury.

OABI bridges resources across local, state, and federal entities, including Texas and federal military forces. The office comprehensively reviews and assesses existing programs across the HHS Enterprise and elsewhere to determine gaps and duplication of services, and it recommends and facilitates the development of new programs to meet the growing need.

HHSC's Rider 66 of the GAA for 2010-11 requires the Executive Commissioner to conduct a study regarding the need for community support and residential services for individuals suffering from acquired brain injury by September 1, 2010.

#### **4.5.9 Office for the Elimination of Health Disparities**

The Office for the Elimination of Health Disparities (OEHD) assists HHS agencies in eliminating health disparities. OEHD works with internal and external stakeholders to affect federal, state, and local policies to address disparities in health and human services and outcomes. OEHD provides administrative support to: the Health Disparities Task Force, which makes biennial recommendations on health disparities to the Legislature, and the African-American Legislative Summit on Health and Human Services, a biennial, statewide meeting that convenes policy makers and community stakeholders to discuss and develop policy interventions to improve access to underserved populations. Other significant policy initiatives include efforts to implement culturally and linguistically appropriate services standards for care and the collection of appropriate health-care data to identify disparities.

The OEHD Resource Clearinghouse provides access to research material, culturally appropriate brochures, and health education incentives. The resource clearinghouse is available to HHS staff, as well as the public. OEHD also provides ongoing training and presentations on subjects related to health and human service disparities, health literacy and cultural competency.

OEHD provides technical assistance and resources to HHS peers and historically disenfranchised communities to initiate and augment existing efforts to address health and human services disparities at the state, regional, and local levels. OEHD

works to locate funds and resources from public and private entities to support local and regional efforts.

#### **4.5.10 Community Resource Coordination Groups of Texas**

Community Resource Coordination Groups (CRCGs) originated with S.B. 298, 70<sup>th</sup> Legislature, Regular Session, 1987, which 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. More than 160 CRCGs now exist.

S.B. 1468, 77<sup>th</sup> Legislature, Regular Session, 2001, broadened the charge to include the adult population. Some communities have added 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 multi-county CRCG, while others are single-county CRCGs.

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.

Local CRCGs are not directly funded by federal or state dollars, but rely on agency coordination and support or resources from other organizations. Some CRCGs have outside funding to support their efforts to obtain a service coordinator position or to secure flexible funding for services. Currently, HHSC directs a small amount of direct service dollars to the child-serving and adult-serving CRCGs in El Paso, to respond to the need for flexibility in services for families in the military, youth being discharged from correctional facilities, and families at risk of relinquishing custody in order to access treatment.

Mental health care is the most frequently identified service need for children and youth referred to local CRCGs. During 2008, approximately 66 percent of the children and youth served by CRCGs were at risk of being removed from their homes largely due to the need for behavioral health intervention.

One program that provides a response to the need for behavioral intervention is the Texas Integrated Funding Initiative (TIFI). HHSC provides oversight to TIFI to enhance local child-serving mental health systems through demonstration of a System of Care service delivery approach in local communities and through oversight from a consortium of state child-serving agency stakeholders and an equal number of family and youth representatives.

### **4.5.11 Texas Autism Research and Resource Center**

House Bill 1574, 81<sup>st</sup> Legislature, Regular Session, 2009, required HHSC to develop an autism resource center. The purpose of the Texas Autism Research and Resource Center is primarily to provide greater support to people with autism and their families through more centralized information about state and local autism services. It will also provide information about resources and research on autism and other pervasive developmental disorders (PDD). Additionally, the Center is required to support professionals who interact or work closely with individuals with autism through training and development activities. Effective November 2009, HHSC entered into an interagency agreement with the Department of Aging and Disability Services (DADS) to manage the project for HHSC.

A statewide collaborative among universities, educational service centers, and others involved in professional development, training, and research related to autism has been established to provide input and guidance to the initial goal of creating a centralized website for parents, professionals, and others looking for relevant, up-to-date resources and research information relating to autism and PDD.

### **4.5.12 Technology Resources Planning**

Statewide and agency planning provides a road map for the implementation of Enterprise-wide and agency-specific technology solutions that will result in more efficient expenditures of limited resources and more effective delivery of services to Texans and agency constituents. These planning elements—The Technology Assessment Summary and The Technology Initiative Alignment—are contained in Chapter 10.

### **4.5.13 Strategic Staffing Analysis and Workforce Plan**

The Health and Human Services Strategic Staffing Analysis and Workforce Plan for the planning period 2011-15 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 E.

### **4.5.14 Historically Underutilized Businesses Plan**

The HHS System administers programs to encourage contract participation by historically underutilized businesses (HUBs). The System's HUB programs are described in Appendix G.

## 4.6 HHSC Initiatives

### 4.6.1 Medicaid Initiatives

#### **Pilot Programs to Encourage Healthy Behaviors**

Senate Bill 10, 80<sup>th</sup> Legislature, Regular Session, 2007, directed HHSC to implement a pilot program in one region of the state to provide positive incentives to Medicaid clients who lead healthy lifestyles by participating in certain health-related programs or engaging in certain health-conscious behaviors, resulting in better health outcomes for those recipients. Two examples of these health-related programs are the Medicaid Child Obesity Prevention Pilot described earlier in this document and the Smoking Cessation pilot program described below.

#### ***Smoking Cessation Pilot Program***

Pursuant to S.B. 10, HHSC implemented a tobacco cessation pilot program to promote healthy lifestyles for STAR+PLUS members in the Bexar service area. Pilot participants were randomly assigned to one of three intervention groups and were asked to set a date to stop smoking. One group received face-to-face counseling, another received phone counseling, and the control group received the anti-smoking help currently available through Medicaid, including over-the-counter and prescription medications. Participants are surveyed four times in the course of a year to track their progress and determine the success rate for each group. HHSC expects to have completed an analysis of the pilot by the fall of 2010.

#### **Tailored Benefits Package**

S.B. 10 directed HHSC to develop a tailored benefits package for children receiving Medicaid who have special health-care needs. Additionally, HHSC's Rider 59 in the 2010-11 GAA directs HHSC to enroll children with disabilities into managed care programs to improve and coordinate their acute care services. Pursuant to this legislation, Medicaid-eligible SSI and SSI-related children will be enrolled in managed care and will continue to receive the full set of Medicaid benefits for which they are currently entitled.

#### **Medicaid Buy-In for Children**

S.B. 187, 81<sup>st</sup> Legislature, Regular Session, 2009, directs HHSC to implement a Medicaid Buy-In program for children up to age 19 who have disabilities and family income up to 300 percent of the federal poverty level. Children in the Medicaid buy-in program will be eligible for the same state plan services as other Medicaid children and have the same service delivery model options as children in Supplemental Security Income (SSI) Medicaid. Medicaid Buy-In participants may be required to pay a monthly premium, depending on their earned and unearned

income. HHSC is currently developing the program, with a planned implementation date of January 2011.

### **Medicaid Substance Abuse Benefits**

The 2010-11 GAA (Article IX, Section 17.15, of S.B. 1, 81<sup>st</sup> Legislature, Regular Session, 2009) directs HHSC to implement comprehensive substance abuse benefits for adults in Medicaid. The anticipated effective date for the benefit is September 1, 2010. HHSC must analyze and provide data to the LBB related to the provision of substance abuse treatment services. The data will be available for review by the 2013 legislative session.

### **Long-Term Care Partnership**

To increase awareness about the importance of planning for long-term care needs, the “Own Your Future Campaign” was launched by the federal government in January 2005 to provide information about long-term care planning. The Texas awareness campaign was subsequently launched by Governor Perry in 2006 with the distribution of more than 2.8 million mail pieces to Texans between the ages of 45 and 65, providing information about planning for long-term care needs. The website [www.ownyourfuturetexas.com](http://www.ownyourfuturetexas.com) was also launched to offer additional resources. DADS maintains the site, and other agencies that offer resources to further help people plan for long-term care are linked through the site.

In addition, S.B. 22, 80<sup>th</sup> Legislature, Regular Session, 2007, authorized HHSC, DADS, and Texas Department of Insurance to create and implement the Texas Long-Term Care (LTC) Partnership program. LTC Partnership programs are public-private partnerships between state agencies and private insurance providers to encourage individuals to plan for their future long-term care needs with the purchase of high-quality long-term care insurance. The federal Deficit Reduction Act of 2005, signed in February 2006, authorized the expansion of LTC Partnership programs from the original four pilot states to all states as a means to help reduce Medicaid expenditures by delaying or eliminating the need for individuals to rely on Medicaid for LTC services.

HHSC is further developing the “Own Your Future” awareness program, to include another statewide mail-out of additional informational material on long-term care planning and the LTC Partnership program.

### **Specific Frew Initiatives**

HHSC received \$150 million in state funding for the 2008-09 biennium for strategic initiatives to expand children's access to Medicaid services. The various proposed initiatives were considered by the Frew Advisory Committee, which consists of various stakeholders and experts in the field of children's health care. As a result, 22 initiatives were selected for implementation, described below.

- **First Dental Home**—A new Medicaid reimbursement code for dentists providing an oral evaluation, application of fluoride varnish, and education to parents for Medicaid children 6 months through 35 months of age.
- **Oral Evaluation and Application of Fluoride Varnish in the Medical Home**—A new Medicaid reimbursement code for physicians providing an oral evaluation, application of fluoride varnish, and education to parents for Medicaid children served 6 months through 35 months of age.
- **Mobile Dental Unit in the Valley**—A mobile unit and a link to a dental home for Medicaid children who do not have a regular source of dental care.
- **Integrated Pediatric Mental Health Pilots**—Throughout the state, integrating mental health access during a visit to the primary care provider.
- **Pediatric Subspecialty Access Improvement**—A new Medicaid reimbursement code for pediatric subspecialists consulting with a primary care provider, and development of referral guidelines for primary care providers to know when to refer for key pediatric specialty conditions.
- **Migrant Family Information System Interface**—A data exchange between the Texas Education Agency and HHSC to link data related to migrant farm worker families who may be enrolled in Medicaid.
- **Study of Vitamins and Mineral Coverage in Texas Medicaid**—To determine whether there are vitamins and/or minerals that are the sole or primary source of treatment for specific pediatric conditions.
- **Community Health Worker / Promotora Pilots in Emergency Rooms**—Pilots throughout the state, to examine the effectiveness of using community health workers / promotoras in hospitals with high emergency room use by Medicaid clients for non-acute care, to connect them with a medical home.
- **Telemedicine Pilots for Pediatric Subspecialty Access**—Throughout the state, to provide access to pediatric subspecialists through telemedicine.
- **Consultation and Referral Network for Pediatric Subspecialty Access**—For primary care providers to consult with pediatric subspecialists.
- **Eligibility and Health Identification Card**—Supplies providers with electronic verification of client eligibility for Medicaid and allows providers to access medical and prescription drug claim history for Medicaid clients.
- **Raising Texas Key Developmental Stages Calendars**—For mothers of Medicaid-eligible infants.
- **Student Loan Repayment for Physicians and Dentists Serving Medicaid Children**—For 300 physicians/dentists each year, at \$140,000 for each provider, over four years, for serving a minimum number of Medicaid children.
- **CPT Code Study**—A review of all medical procedure codes for which policy and reimbursement rates have yet to be established, to determine which codes are appropriate for specific pricing and medical policy.
- **Provider Enrollment and Online Provider Look-Up Enhancements**—To a currently available online provider enrollment process and look-up system.

- **Provider VOICE**—A web-based process for health-care professionals to submit Medicaid system issues and solutions to HHSC.
- **Medicaid Curriculum in Medical and Dental Schools**—A curriculum for dental schools and medical residency programs, regarding the Medicaid program the children it serves, marketing for the curriculum, and an on-site Medicaid community health elective for medical residency students.
- **Health Home Pilots**—For entities to fully transform into a comprehensive health home for children enrolled in Medicaid; with multiple pilot sites and medical home structures, HHSC can learn what is most effective in improving health status of children on Medicaid.
- **Transportation / Child Care Pilots for Siblings**—To learn why children enrolled in Medicaid do not keep scheduled health-care appointments; HHSC will receive specific recommendations for projects to reduce the number of missed appointments.
- **Call Center Technology for the Medical Transportation Program**—System enhancements to the Medical Transportation Call Center, for improved quality of services and improved access to medical transportation.
- **THSteps Lab Improvements**—For the collection of laboratory specimens.
- **Additional Printing of Developmental Calendars**—Distribution of additional developmental stages calendar to mothers of Medicaid eligible infants.

### **Other Medicaid Initiatives**

The following topics are discussed above, in Section 4.3, External Assessment: Challenges and Opportunities, and Planned Actions:

- Medicaid Eligibility and Health Information System,
- Texas Nurse-Family Partnership,
- Health Management Program,
- Preventable Adverse Events, and
- Drug Utilization Review.

The STAR Health program is discussed in the Major Accomplishments of the HHS System section in Chapter 2, Section 2.6.1, STAR Health, and Women’s Health Program is discussed in Section 4.3.2 Managing Increasing Medicaid Costs, earlier in this chapter.

### **4.6.2 Other HHSC Initiatives**

#### **Texas Disaster Case Management—Pilot**

The Texas Disaster Case Management—Pilot (TX DCM-P) serves Texans affected by Hurricane Ike, the third costliest hurricane to affect the U.S., after Hurricanes

Katrina and Andrew.<sup>2</sup> Hurricane Ike made landfall as a Category II Hurricane on Galveston Island at approximately 2:00 a.m. on Saturday, September 13, 2008. There are an estimated 36,000 households in need of and eligible for long-term recovery disaster case management assistance through this pilot. The number of households needing assistance is expected to increase due to outreach done by the three contractors for this grant: Lutheran Social Services Disaster Response, Neighborhood Centers Incorporated, and Deep East Texas Council of Governments.

The TX DCM-P is one of several Disaster Case Management Pilot Programs funded by the U. S. Homeland Security's Federal Emergency Management Agency (FEMA). Funding for this grant is \$65 million, and the grant extends through December 2010. Previous and current DCM-Ps have been funded for Louisiana and Mississippi federally declared disasters. The purpose of the pilot is both to assist victims and to garner information, based on case management activities and outcomes, which will provide FEMA with information to create a permanent future disaster program.

### **Healthy Marriage Program**

The Healthy Marriage Program provides marriage and relationship skills education to parents for the purpose of creating safe, healthy and well-adjusted home environments for children. The program works with regional intermediaries to administer premarital and healthy marriage education services through community or faith-based organizations.

Trained instructors provide services through structured educational classes and workshops that participants can attend on a voluntary basis. These instructors teach marriage/relationship education classes, including communication skills and conflict management, to couples and individuals throughout the region. HHSC continues to work with partners to maximize limited resources and identify new ways of providing these services.

### **Office of Inspector General Public Awareness Campaign**

OIG will create a public awareness campaign to educate the public on the *qui tam* provisions of the state and federal False Claims Acts. These provisions allow citizens to file legal actions in response to fraud schemes and to receive a reward if the action is successful.

In addition to appealing to the general public, OIG will also create education modules for Medicaid providers so they may meet minimum federal requirements for educating their employees on reporting waste, abuse, and fraud as required under the federal DRA. This education will also include information on the *qui tam* provisions of the state and federal False Claims Acts, as many whistleblower cases originate with employees.

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<sup>2</sup> [http://www.nhc.noaa.gov/pdf/TCR-AL092008\\_Ike\\_3May10.pdf](http://www.nhc.noaa.gov/pdf/TCR-AL092008_Ike_3May10.pdf)

Another outreach strategy for OIG will be to create a user-friendly education module for providers on self-reporting. This information will let providers know the steps they need to take if they discover they have billed Medicaid services in error. For providers choosing to work with OIG in this manner, their cooperation is taken into account when it comes to terms of settlement. Also, by working together, there is the added benefit of developing an effective working relationship whereby a provider is less likely to repeat its mistakes.



# Chapter 5

## Department of Aging and Disability Services

### External/Internal Assessment

#### 5.1 Overview

The Department of Aging and Disability Services (DADS) was established by House Bill (H.B.) 2292, 78<sup>th</sup> Legislature, Regular Session, 2003, and became operational in September 2004. As mandated by this bill, the Department provides a continuum of long-term services and supports that are available to older individuals and individuals with disabilities. In addition, the regulatory component of DADS licenses and certifies providers of these services and monitors compliance with regulatory requirements. Senate Bill (S.B.) 6, 79<sup>th</sup> Legislature, Regular Session, 2005, transferred the Guardianship Services Program from the Department of Family and Protective Services (DFPS) to DADS, effective September 1, 2005.

Through its mission, DADS provides a comprehensive array of aging and disability services, supports, and opportunities that are easily accessed in local communities. The biennial strategic planning process gives DADS an opportunity to assess those issues affecting the accomplishment of its mission.

The rest of this chapter is arranged as follows:

- Mission
- External Assessment: Challenges and Opportunities, and Planned Actions
- Internal Assessment;
- Cross-Agency Coordination and Planning Initiatives; and
- DADS Initiatives.

Appendix F includes a description of the agency target populations and service descriptions.

## 5.2 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.

## 5.3 External Assessment: Challenges and Opportunities, and Planned Actions

### 5.3.1 Ensuring the Health and Safety of Individuals Residing in State Supported Living Centers and Community Settings

One of the most critical challenges DADS faces is to ensure the health and safety of individuals with disabilities whom it serves directly in its 12 state supported living centers (SSLCs), the Rio Grande State Center, and through contracted residential and community services providers.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Ensure the safety and well-being of Texans in state-operated and contracted residential facilities, as well as those provided services in their homes.

#### Discussion

The 81<sup>st</sup> Legislature enacted a comprehensive package of legislation, appropriations, and budget riders in response to growing concerns about the quality of care provided through SSLCs and services for individuals with intellectual and developmental disabilities (IDD).<sup>1</sup> In addition to the statutory guidance in legislation and budget riders, the 81<sup>st</sup> Legislature approved Senate Concurrent Resolution 77, which provided legislative approval of the state's settlement agreement with the United States (U.S.) Department of Justice (DOJ) to address needed improvements to the SSLCs.

#### Planned Actions

This new statutory guidance and the settlement agreement include key initiatives providing the SSLCs and related support systems with additional resources to meet

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<sup>1</sup> S.B. 643, 81<sup>st</sup> Legislature, Regular Session, 2009; 2010-11 General Appropriations Act (Article II, Special Provisions, Section 48, S.B. 1, 81<sup>st</sup> Legislature, Regular Session, 2009).

the needs of the individuals they are charged to support, as well as those served in home- and community-based programs.

The key initiatives of S.B. 643, 81<sup>st</sup> Legislature, Regular Session, 2009, include the following:

- Employee and volunteer fingerprint checks and random drug testing;
- Improved training at SSLCs and community programs;
- Video surveillance at SSLCs;
- Forensic center for high-risk alleged offenders;
- Creation of the Office of the Independent Ombudsman;
- Increased inspections of home and community-based services;
- DFPS investigation of abuse and neglect in community intermediate care facilities for persons with mental retardation (ICFs/MR); and
- Investigations database.

Work on these key initiatives began in June 2009 and is targeted for completion on or before September 2011.

Article II, Section 48 of the 2010-11 General Appropriations Act (GAA) (S.B. 1, 81<sup>st</sup> Legislature, Regular Session, 2009) includes provisions for:

- Reducing the number of residents at SSLCs by developing census management plans that limit the number of individuals residing at each SSLC, while respecting individual choice and promoting improved quality of care, better staffing, and effective management at each center;
- Use of the Community Living Options Information Process to ensure that appropriate information is shared with individuals and their families or legally authorized representatives regarding available community placement alternatives, and to help identify individuals who may be interested in moving to the community;
- Additional waiver slots for persons at risk of institutionalization in ICFs/MR;
- Study of managed health care for persons with intellectual and developmental disabilities; and
- Transfer of case management functions for persons enrolled in the Home and Community-Based Services (HCS) waiver program from HCS providers to Mental Retardation Authorities (MRAs).

Projects addressing these provisions began in June 2009 and are targeted for completion on or before September 2011.

The DOJ settlement agreement, signed in June 2009, includes 20 detailed sections related to improvements in quality of care, protections from harm, health professional services, and serving persons in the most integrated setting, among others. As provided under the settlement agreement, three monitors conducted

baseline reviews of each center and identified areas where service delivery improvements are required. They will also conduct compliance reviews every six months to ensure compliance with the elements of the settlement agreement. The settlement agreement has a term of five years and may be terminated for any center once the center reaches substantial compliance for one year with all substantive provisions of the agreement.

### **5.3.2 Meeting Increased Demand for Home and Community Based Services**

Home and community-based services are critical to allow older Texans and those with disabilities to achieve and maintain independence and community integration and to avoid institutionalization. Demand for these services continues to outpace available funding, despite generous increases from the Legislature over the past three sessions.

Strategic Priority: Improve the health and well-being of Texans.

- Provide an outcome-based, quality-oriented system of care.

Strategic Priority: Create opportunities for increased self-sufficiency and independence.

- Assist older Texans and those with disabilities to gain, maintain, and enhance their ability to function independently.

#### **Discussion**

While more than 58,000 individuals are currently enrolled in DADS and STAR+PLUS waiver programs, more than 100,400 individuals are currently on interest lists for those services.<sup>2</sup> Time spent on the interest lists varies by program, but the wait for some programs can be as long as eight to nine years. This large unmet demand makes it essential that the state do all it can to ensure that services are provided in the most cost-effective manner possible.

Reducing expenditures for unneeded or excessive services is critical to the agency's ability to serve a greater number of individuals who are currently on interest lists. The DADS Rider 36 in the 2010-11 GAA directs the agency to "employ utilization management and utilization review practices as necessary to ensure that the appropriate scope and level of services are provided to individuals receiving services in Medicaid 1915(c) waivers." DADS is committed to implementing this direction with the goal that individuals receive no more and no less than the right amount of services to meet their needs.

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<sup>2</sup> Figures are as of December 2009.

## Planned Actions

The 81<sup>st</sup> Legislature appropriated \$150 million in state funds and \$358.6 million all funds for the expansion of the Medicaid waiver and non-Medicaid community programs at DADS. With the additional authorized funding, DADS anticipates serving an additional 7,043 individuals during the 2010-11 biennium. The affordable number is fewer than appropriated because the projected average cost per consumer exceeds the cost assumed in the GAA. Based on the revised targets, DADS is on track to meet enrollment targets for all Medicaid waiver programs.

To ensure effective utilization management across long-term services and supports programs, and to comply with the requirements set forth in DADS Rider 36, DADS has expanded its review activities. For the Community Based Alternatives Program (CBA), Medically Dependent Children Program, Primary Home Care, and Community Attendant Services, dedicated registered nurses have been hired to conduct comprehensive reviews of the quality, appropriateness, and cost-effectiveness of services. Reviews include desk reviews of case documentation from DADS case managers and service provision documents from home and community support service agencies or consumer directed service providers, and also face-to-face interviews with consumers, parents, or other legally authorized representatives. For the HCS, Texas Home Living (TxHmL), and Community Living Assistance and Support Services (CLASS) programs, staff conduct comprehensive reviews of individual plans of care to ensure plans ensure the health and safety of program participants and do not contain unnecessary services. Savings from utilization management allow DADS to serve additional consumers. Utilization review activities will be ongoing.

### 5.3.3 Improving Local Access to Long-Term Services and Supports

At the local level, long-term services and supports are administered by multiple agencies with complex, fragmented, and often overlapping intake, assessment and eligibility functions. As a result, identifying which services are available and where to obtain them can be difficult for many individuals.

Strategic Priority: Deliver the highest quality of customer service.

- Improve agency business practices to create a more coordinated, cost-effective, and customer-friendly service delivery system.

Strategic Priority: Create opportunities for increased self-sufficiency and independence.

- Assist older Texans and those with disabilities to gain, maintain, and enhance their ability to function independently.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with families, stakeholders, community organizations, providers and others in the public to address service delivery issues and ensure customers receive timely, appropriate services.

## **Discussion**

State agency staff, local partner agencies, and contractors must continue to work closely with one another wherever possible and put in place formal and informal processes to improve the way frontline workers provide information, make referrals, and track individual cases. To address this challenge, DADS will continue expansion of the Aging and Disability Resource Center (ADRC) initiative, which began as a federal grant from the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS). ADRCs serve as “no wrong door” to services and are comprised of a network of local service agencies, coordinating information and access to public long-term services and support programs and benefits through various models of single or multiple points of entry. Models include physical co-location, virtual co-location, or a combination of the two. Key ADRC partner agencies include the three DADS “front doors” (Regional and Local Services offices, mental retardation (MR) Authorities, and Area Agencies on Aging (AAA)) and may also include Texas Health and Human Services Commission (HHSC) benefit offices, hospital discharge planners, mental health authorities, Independent Living Centers, and other community organizations. ADRCs have now been established in eight areas of the state.

In addition, the Department’s Community Living Program (CLP), which was originally funded in fiscal year (FY) 2009 by a \$923,708 grant from AoA, has created a partnership with the Central Texas ADRC and Scott & White Healthcare to establish a nursing home diversion program for individuals at imminent risk for nursing home placement and Medicaid spend-down. In September 2009, DADS was awarded a new \$396,600 grant from AoA to support an additional CLP between DADS, the AAA of Tarrant County and the ADRC of Tarrant County. This CLP project site will also target caregivers and older persons at imminent risk of nursing home placement and Medicaid spend-down. Both project sites have a U.S. Department of Veterans Affairs (VA) component, wherein the ADRCs have a direct, fee-for-service arrangement with the local VA hospital system to provide care transitioning for veterans from the hospital to home. The CLP for Central Texas began in October 2008 and will end in March 2011. The CLP for Tarrant County began in October 2009 and will end in September 2010. A possible source of future funding for both CLPs is the AoA.

## **Planned Actions**

DADS was awarded additional funding in FY 2009 to establish a ninth ADRC and enhance the capacity of the current eight sites. This ninth ADRC was established in

June 2010. In FY 2010, DADS plans to establish two more ADRCs. Additionally, DADS will work with the ADRC State Advisory Council to develop a plan for expanding the ADRC model to 20 locations by 2020.

### **5.3.4 Recruiting and Retaining Qualified Regulatory Staff**

The ability to recruit and retain a fully staffed and well-trained surveyor workforce is essential for DADS regulatory programs. However, DADS is challenged by a statewide shortage of nurses and other professionals as well as the time- and resource-intensive training required for surveyors.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Ensure the safety and well-being of Texans in state-operated and contracted residential facilities, as well as those provided services in their homes.

Strategic Priority: Strengthen and support the health and human services workforce

- Recruit high-quality staff.
- Recognize and reward employee performance.
- Encourage employees to work together across agencies to achieve common goals.

### **Discussion**

Surveyors at DADS cover a variety of facilities and programs, including the following:

- Nursing facilities;
- Assisted living facilities;
- Home and community support services agencies;
- Intermediate care facilities for persons with intellectual and developmental disabilities (ICFs/MR);
- Adult day care facilities;
- Home and Community-Based Services waiver contracts; and
- Texas Home Living waiver contracts.

DADS surveyors come from a number of professional disciplines, including registered nurses, social workers, nutritionists, pharmacists, architects, engineers, and Life Safety Code specialists. Teams of specialists conduct annual facility surveys, while DADS assigns one or more surveyors from specific areas of expertise to investigate complaints and self-reported incidents.

Properly training a surveyor is time and resource intensive. This training is scheduled at an out-of-state location by CMS, and it can take from six months to a year for a surveyor to be fully prepared to assume all job responsibilities.

## **Planned Actions**

Since 2005, DADS has taken a variety of approaches to meet the challenge of recruiting and retaining regulatory surveyors and other staff on an ongoing basis. These approaches have included recruiting at job fairs, advertising in professional nursing publications, advertising job vacancies in newspapers, recruiting through direct mail, and using perpetual postings on accessHR, the human resources site for the Texas Health and Human Services (HHS) System. In addition, DADS has raised base salaries for some surveyor job classifications to both recruit and retain staff.

To improve retention, DADS continues to diversify the structure and composition of surveyor teams to meet local demands and optimize local workforce characteristics. The Department is cross-training staff to effectively survey in multiple areas, rather than one regulatory program area. Magnet Area Training (MAT), which is a pilot project between DADS and CMS, brings required training to Texas, removing the need for surveyors to travel to out-of-state training locations. Increased use of MAT will save on training expenditures and make cross-training efforts viable and affordable. Additionally, Regulatory Services provides tools to assist surveyors and other staff in more effectively and efficiently carrying out their job responsibilities by increasing flexibility in work schedules and office locations and improving methods of communication.

### **5.3.5 Preparing for the Aging of the Texas Population**

Over the next 30 years, the number of Texans 60 years or older is projected to increase significantly. As this population grows, DADS must continue to provide additional supports to state government, local communities, and individuals to address aging-related issues.

#### Strategic Priority: Encourage partnerships and community involvement

- Develop partnerships with families, stakeholders, community organizations, providers and others in the public to address service delivery issues and ensure customers receive timely, appropriate services.

#### Strategic Priority: Create opportunities for increased self-sufficiency and independence

- Assist older Texans and those with disabilities to gain, maintain, and enhance their ability to function independently.

#### Strategic Priority: Improve the health and well-being of Texans

- Emphasize health promotion, primary care, disease prevention, and early intervention for improved long-term health outcomes.

## Discussion

In 2010, the population of Texans 60 years of age or older is projected at 3.7 million, representing 14 percent of the total Texas population. This population is projected to reach 5.4 million by the year 2020; 7.5 million by 2030; and 10 million by 2040, when it will represent approximately 22 percent of the total population. To address this demographic shift, DADS continues to develop and implement initiatives and programs focused on a number of issues including, but not limited to, the need for building community capacity to serve the aging population, promoting wellness, and increasing access to informal caregiver support services.

## Planned Actions

The Aging Texas Well (ATW) initiative, established in 1997 and formalized under Executive Order RP 42 in 2005, charges DADS with offering guidance to state government and local communities about preparing for an aging Texas population.

The ATW initiative supports projects that promote wellness and ameliorate the problems associated with aging. These projects include:

- Demonstration projects that promote the adoption of evidence-based programs to improve health status and symptom management;
- Technical assistance to local communities that are seeking to measure and improve their ability to serve a growing aging population;
- Research and publications, such as the ATW Aging Indicators Survey, that provide data and analysis of the needs of the needs of older Texans; and
- Partnerships with public, private, and state agency organizations to build community capacity to serve the aging populations of Texas.

Texercise is a statewide ATW program that was developed by DADS to educate and involve older Texans and their families in physical activities and proper nutrition. The Texercise program promotes individual activity, community events, and policies that support fitness in all life areas. Through the Texercise program, participants are provided with an array of educational, motivational and recognition resources that encourage participation in healthy lifestyle habits. These resources include the Texercise handbook, exercise DVD, resistance bands, and T-shirts, which are all provided at no cost to participants. Texercise program activities will continue on an ongoing basis.

In Texas and across the country, relatives and friends who provide unpaid care, known as informal caregivers, are considered the backbone of the long-term services and supports system. Caregivers need information about available services, including respite, support groups, and other services. Services such as respite provide temporary relief to caregivers from their duties and may be provided in home or institutional settings. For example, a respite program might offer in-home care for an aging individual to allow the person's spouse to go grocery shopping. Numerous state and federally funded programs offer respite services, including

Medicaid waiver programs and Older Americans Act services administered by AAAs. Federal funding through the Lifespan Respite Grant and from the passage of H.B. 802, 81st Legislature, Regular Session, 2009, will enable DADS to establish a Lifespan Respite Services program to promote the provision of respite services through contracts with eligible community-based organizations or local governmental entities.

The Lifespan Respite Program began in October 2009 with the establishment of a Texas Respite Coalition. DADS is finalizing the contract with the Texas Association of Regional Councils and the Texas Association of Area Agencies on Aging to become the Department's statewide Respite Coordination Center. In addition, DADS has released a Request for Proposal to fund at least three local communities to expand the availability of respite services. The Lifespan Respite Program will end in September 2012, unless AoA continues the program.

## 5.4 Internal Assessment

### 5.4.1 Maintaining and Developing the Workforce: Maintaining Essential Regulatory and State Supported Living Center Staff

Vital to the effective and efficient delivery of services is DADS' ability to recruit and retain a well-trained and highly 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 turnover and an increase in the vacancy rates in various positions such as surveyors, mental retardation assistants, nurses, psychiatrists, and psychologists.

DADS faces recruitment challenges resulting from an increased shortage of qualified applicants, particularly in rural areas. The demand for nurses is projected to outpace supply due to an aging workforce nearing retirement, a decline of enrollment in nursing schools, and an increasing number of nurses changing careers in favor of less stressful and more flexible work environments. The number of licensed practicing psychiatrists in Texas is relatively small, roughly 1,500, with very little growth projected in the future.

Another recruitment challenge faced by DADS originates in competition with private sector and retail employers. As a result of equity adjustments for nurses in FY 2008, DADS initially was able to attract more applicants for vacant positions. However, due to competition also raising entry-level salaries, DADS was again at a competitive disadvantage. DADS is also continually challenged with filling pharmacist positions. The growing demand for pharmacists in the retail industry,

coupled with the demand for higher salaries, has put DADS at a competitive disadvantage in this field as well.

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 2009 was 14.4 percent. However, the turnover at SSLCs was even higher, at 34.95 percent. Contributing to this high turnover are registered nurses at 28.81 percent, licensed vocational nurses at 34.80 percent, psychiatrists at 35.64 percent, psychologists at 23.08 percent, and mental retardation assistants at 47.39 percent. In all cases, the turnover is slightly lower than in the previous year. This reduction in turnover is likely the result of the present economy, with the unemployment rate at 8.0 percent in Texas.

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 SSLCs. 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 SSLC.

## **5.4.2 Addressing Infrastructure Needs**

### **Increasing Capacity of DADS Information Technology Resources**

With the consolidation of the HHS System agencies in September 2004, the demand for information technology (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 for day-to-day production support as well as new development projects, DADS IT staff is augmented through the use of contractors. Increasing contractor costs, particularly for production support, are difficult to sustain, and they limit availability of funds to take advantage of Department of Information Resources' new Deliverables Based IT Services for short-term development projects. An

investment in additional employees at appropriate skill levels to perform production support will benefit DADS by allowing more economical use of contractors for development projects. 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.

### **Addressing Increased Need for Information Technology Support at State Supported Living Centers**

Critical to ensuring communication among residents, their families, and staff is reliable telecommunication systems and IT hardware at the SSLCs. The telecommunication systems at the SSLCs 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 SSLCs are no longer supported with maintenance contracts. If system failure occurs, repairs on current systems at SSLCs may not be available due to shortage of refurbished parts.

The IT network switches at SSLCs 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 particular, the servers are a critical concern. Eight of twelve file and print servers at the SSLCs fluctuate at or above 95 percent capacity. This prevents the ability to store new and modified documents, adversely affects network performance as it delays response time between the servers and personal computers, drastically slows down the time it takes staff to log on and off their workstations, and seriously affects staff efficiency and productivity in providing services to residents. These servers are dangerously close to failure. Delivery of services to residents at SSLCs is drastically affected if the servers fail, causing SSLC staff to lose valuable data and their ability to communicate by e-mail, to document medical information and progress notes, and to access automated records and files. Failure is unacceptable and must be avoided. Temporary short-term solutions have been implemented, and DADS is exploring long-term solutions with the vendor and the Department of Information Resources.

In addition, in the event of a power outage, the UPS should provide backup power for all network switches and servers at the SSLCs, allowing accessibility to data on residents of SSLCs and access to critical data for staff to provide critical medical care. However, the backup power source is outdated and has a high failure rate.

Updating the IT hardware and telecom equipment at SSLCs will provide more reliable systems of communication for residents, their families, and staff. Improved reliability will enable faster problem resolution and less downtime at the SSLCs.

For the 2010-11 biennium, DADS received funding to replace the voicemail systems at 11 of the 12 SSLCs, as well as to replace the copper trunks with Integrated Services Digital Network Primary Rate Interface lines at 10 of the 12 SSLCs. This

funding includes the SSLC Network Switch/UPS Refresh, which involves replacement of distribution network switches and UPS upgrades at all 12 SSLCs. This translates to faster problem resolution and less downtime at the facility. Both projects are currently in the early stages of internal governance approval and implementation. DADS anticipate completion of both of these projects by August 2011. DADS IT will do everything possible to complete this effort sooner.

### **5.4.3 Improving Data Quality and Use: Creation of a DADS Single Service Approval System for All DADS Long-Term Services and Supports**

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 Online (SASO) and the MR Client Assignment and Registration (MR CARE) mainframe system. The purpose of these systems is to enroll consumers in long-term services and supports programs and to verify their services.

The Department processes billing and payment requests through two separate systems. Billing and payment requests for HCS and TxHmL providers are processed through the MR CARE mainframe system. Billing and payment requests for other DADS' programs are processed through the Claims Management System operated by the Texas Medicaid & Healthcare Partnership (TMHP).

The Department received funding approved by the 81<sup>st</sup> Legislature for the 2010-11 biennium to create a DADS Single Service Approval System for long-term services and supports. The benefits of creating DADS Single Service Approval System and making system improvements to the SASO include:

- Consolidation of all consumer information/assessments into a common database, eliminating the possibility of duplicate enrollment in more than one DADS Medicaid 1915(c) waiver program; and
- Enhanced capability for data inquiries, analysis, program comparison, and reporting.

Along with the creation of a DADS Single Service Approval System, enhancements will be made to automate submission of service authorization documents, such as levels of care and individual service plans.

As part of the effort to create a DADS Single Service Approval System for long-term services and supports, the Department has plans to integrate billing and payments processing for HCS and TxHmL into the Claims Management System operated by TMHP. This would increase efficiencies by allowing:

- Use of the same processing rules for all DADS long-term services and supports programs; and

- Enhanced federal match for all system modifications and improvements when changes need to be made.

## 5.5 Cross-Agency Coordination and Planning Initiatives

### 5.5.1 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. More than two-thirds of unemployed individuals with disabilities would prefer to be working.

Supported employment (SE) is a service that 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 programs that serve individuals with developmental disabilities: five home- and community-based waiver programs (HCS, TxHmL, CLASS, Consolidated Waiver Program, and Deaf-Blind and Multiple Disabilities, community ICFs/MR, SSLCs, and state-funded vocational services with SE services for individuals with intellectual and developmental disabilities (IDD) provided through local MRAs. Individuals with IDD utilize SE at a low rate and more often participate in segregated day activities. Some factors that contribute to low SE utilization are:

- Shortage of qualified SE providers;
- Small pool of available employers;
- Inconsistent coordination between the Department of Assistive and Rehabilitative Services (DARS) and DADS; and
- Other barriers, such as lack of access to transportation.

Much attention and work has been focused recently on addressing barriers to SE utilization. In 2006, DADS joined the State Employment Leadership Network (SELN), a network of state developmental disability agencies (a joint organization of the National Association of State Directors of Developmental Disabilities Services and the Institute for Community Inclusion at the University of Massachusetts Boston). SELN provides technical assistance to members regarding SE, such as identification of obstacles and best practices. SELN is currently assisting in DADS' effort to increase provider competence by offering SE training through a variety of media, including:

- Monthly webinars;
- Presentations at provider and consumer-targeted conferences;

- A webpage within the DADS site;
- Six regional forums around the state;
- Coordination with DARS Medicaid Infrastructure Grant, including distribution of Medicaid Buy-In information to individuals on DADS' interest list;
- An Employment First pilot in HCS and at SSLCs; and
- A facilitated referral process to DARS at two SSLCs.

DADS has improved coordination with DARS through revision and re-execution of an interagency memorandum of agreement designed to reduce duplication and fragmentation of employment services provided to the shared client population of both agencies. DADS is also in the process of revising SE definitions and guidance, developing an SE use manual for providers, and tracking the number of consumers referred to DARS for SE.

With a greater percentage of consumers employed in competitive jobs, Texas businesses will achieve more diversity and a larger talent pool, and the state will move closer to achieving its goal of providing consumers maximum choice and freedom. Consumers will be more integrated into their communities, contribute to economic growth, and benefit from greater economic freedom and self-determination.

## 5.6 DADS Initiatives

### 5.6.1 Long-term Services and Supports Initiatives

#### **Continuing Needs of Individuals “Aging Out” of Children’s Disability Services**

By federal law, children with disabilities are entitled to an extensive array of Medicaid services, including Comprehensive Care Program-Private Duty Nursing (CCP-PDN) and Personal Care Services. Many of those services are no longer available as entitlements once the individual turns 21 (also known as “aging out” of services). As the individual prepares to move into an adult Medicaid waiver (e.g., CBA, STAR+PLUS), an assessment to determine needs and service levels is conducted and sometimes results in a reduced level of nursing services or includes a combination of nursing and attendant services when the consumer had previously received only nursing. Because of cost limits in Medicaid waiver programs, some individuals receiving a significant level of CCP-PDN are unable to receive Medicaid waiver services within the program’s cost limits, making them ineligible for the program.

The DADS Rider 36 in the 2010-11 GAA sets 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 state 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 employ utilization management and review practices to ensure individuals receive the appropriate scope and level of services, while maintaining compliance with the CMS cost-effectiveness requirements.

### **Waiver Standardization and Streamlining Initiative**

Created under separate administrative authorities of different legacy HHS 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. Following the consolidation of the HHS agencies in FY 2005, DADS began examining variations across the waivers. Examples include:

- Level of care processes,
- Adaptive aid authorization requirements and criteria,
- Utilization review of Individual Service Plans/Individual Plans of Care,
- Minor home modification cost limits and policies, and
- Basic waiver terminology.

Recent accomplishments of Waiver Standardization and Streamlining Initiative include:

- Elimination of the requirement mandating physician's signature on all waiver level of cares;
- Standardization of a number of forms across waivers; and
- Revision, clarification, and standardization of closure codes in the Community Services Interest List system.

Work in progress includes standardization of:

- Minor home modification lifetime cost caps,
- Utilization review processes and procedures,
- Adaptive aids prior authorization forms and procedures, and
- Waiver handbooks.

### **Texas Direct Service Workforce Initiative**

The direct service workforce plays a critical role in the home and community-based system of services for older Americans and Americans with disabilities. Direct service workers (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. DSWs provide a wide range of services including cooking and

feeding, personal care and hygiene, transportation, recreation, housekeeping, and other related supports. DSWs aid the most vulnerable members of the community, and their work is physically, mentally, and emotionally demanding.

Demand for DSWs in the U.S. is increasing rapidly due to a number of factors, including:

- the growing U.S. population;
- the aging of the baby boom generation;
- the increasing prevalence of cognitive and developmental disabilities;
- the aging of family caregivers; and
- the national commitment to and steady expansion of community and in-home services for individuals needing long-term services and supports.

National demand for DSWs is projected to increase by 35 percent between 2006 and 2016, totaling approximately 1.3 million new positions nationwide and more than 150,000 new positions in Texas. At the same time that demand is increasing, the traditional labor pool of DSWs is shrinking.

DADS stakeholders have identified the need to improve pay, benefits and other aspects of recruitment and retention for direct service workers. At the direction of the HHSC Executive Commissioner, HHSC and DADS established and provided staff support to a council to address these issues.

The council's charge is to produce a report for the Executive Commissioner analyzing current and anticipated funding needs, as well as policy and funding recommendations related to the HCS workforce. The council submitted its preliminary report in May 2010, and will submit a final report to the HHSC Executive Commissioner by November 1, 2010.

### **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 35 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. In an effort to reduce this growing need, DADS is coordinating with DFPS and individuals referred to the Guardianship program to thoroughly research and identify viable alternatives to guardianship. For example, viable alternatives include money management services, payee representatives, powers of attorney, and other services available through DADS waiver programs, such as CBA and HCS.

## **Volunteer and Community Engagement Partnerships**

Through the Volunteer and Community Engagement (VCE) Unit, DADS develops partnerships with public, private, non-profit, and faith-based organizations to help create awareness of DADS and the aging and disability network's programs and services and to expand and enhance existing resources. DADS relies on community partnerships to enhance public awareness, outreach, and funding of services. Partnerships help eliminate duplication and fragmentation in community outreach and programs, and they provide the people DADS serves with more choices and opportunities for receiving critical information, resources, and services.

For example, DADS has developed a dynamic partnership with Sam's Club Pharmacy. The partnership supports the health and wellness of Texans by:

- Creating awareness of vital long-term care services and programs through ongoing in-store events across the state;
- Promoting DADS' Texercise program through ongoing distribution of Texercise educational materials;
- Involving DADS and the aging network in the planning of the program and launch events; and
- Encouraging public participation with special emphasis on the senior population through AAA marketing and free access to the clubs.

Recruiting public, private, nonprofit, and faith-based partnerships is an ongoing effort by the VCE Unit in support of its goal to expand and increase the number of volunteer programs and partnerships.

## **Texas Healthy Lifestyles: An Evidence-Based Disease Prevention Grant**

In 2005, through a \$250,000 grant from AoA, DADS implemented an evidence-based disease prevention project titled Texas Healthy Lifestyles. The purpose of this initiative was to promote healthy aging, improve overall health, and reduce the incidence of emergency room visits and hospital admissions. The local grantees are located in Harris County (Houston), Bexar County (San Antonio), and Bryan/College Station. These projects focus on promoting physical activities for seniors to enhance strength, stability, and coordination to reduce potentially debilitating falls and to improve overall health.

In September 2009, DADS was awarded new supplemental funding from AoA (\$200,000) to support these efforts. The project is expanding to 5 new sites in the Houston area, 11 counties surrounding Bexar County, and the Belton-Temple-Killeen and Waco areas. The project is also establishing partnerships with the Veterans Health Administration and Scott and White Healthcare. Additionally, DADS submitted a third application to AoA in February 2010, for \$1.25 million, to expand additional project sites in the counties surrounding San Antonio, Tarrant County (Fort Worth), El Paso, and in selected sites throughout East Texas.

## **Fall Prevention Project**

DADS continues to fund the implementation of “A Matter of Balance,” a fall prevention strategy in 236 counties in Texas. Participating AAAs 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 goal of “A Matter of Balance” is to reduce the number of falls in older Texans through education. The project addresses 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.

## **Increasing Access to Behavioral Health Services and Supports**

The incidence of behavioral health issues is increasing in persons with a physical or intellectual/developmental disability and in the aging population. The additional challenge of a behavioral health diagnosis can further limit these individuals’ ability to become fully integrated within the long-term services and supports system. It is anticipated that the incidence will further increase and place additional demands on DADS system of services and supports.

In recognition of this growing need, DADS has begun efforts to address the behavioral health needs of consumers across all settings, in both institutional settings (e.g., nursing facilities; ICFs/MR) and community services (e.g., Medicaid waiver programs). Several of DADS programs, but not all, currently include services (e.g., behavioral supports in HCS) that are designed to address this need. However, services may not be available to all those in need. Additionally, for some individuals who do receive a particular service, the provider base may be limited in terms of availability and quality.

Some of DADS programs could be improved by including a wider service array, such as behavior analysis, crisis management, and counseling services. For some individuals, additional services and supports could enable them to remain in their homes. In turn, this may lead to fewer admissions to a state hospital, NF, or other institution. Development of new services and supports and more qualified provider base may require extensive resources and skills development in all programs.

DADS is currently engaged in a number of efforts to improve behavioral health services and supports, and intends to continue and expand those efforts in the coming years. Some are listed here.

- Positive Behavior Management Training—workshops on positive behavior management, providing specialized training for all DADS service providers; the target audience includes IDD providers, including provider staff who develop or oversee behavior supports plans, as well as direct service staff.
- Behavioral Health Supports Workgroup—established in coordination with DSHS to improve the delivery of comprehensive services for persons with IDD and intensive behavioral needs.
- Behavioral Health Pilot—a specialized project that is part of the Money Follows the Person Demonstration in Bexar County that provides two new services, cognitive adaptive training and adult substance abuse training services; DSHS has the lead on this initiative.
- NF Quality Review—an annual face-to-face survey of NF residents across the state, to be expanded to include questions about depression.
- NF Behavioral Health Collaborative—an interdisciplinary workgroup comprised of NF providers, community MHMR centers, and DADS staff, with a focus on identifying ways to better address the behavioral health needs of NF residents.

### **H.B. 1574 Autism Initiatives**

H.B. 1574, 81<sup>st</sup> Texas Legislature, Regular Session, 2009, established two important initiatives designed to benefit individuals with autism spectrum disorder (ASD), their families, and/or practitioners:

- Development of a study to determine the costs and benefits of establishing a pilot program to provide services to adults with autism, and
- Establishment of a state autism resource center.

HHSC was given responsibility for the initiatives and assigned the management of both projects to DADS. Initial work began on both initiatives in August 2009.

As mandated, a comprehensive study is being conducted during FY 2010 to determine the benefits, costs, and potential cost-savings associated with developing a seamless system of support for adults who have an ASD or a related disability with similar support needs. The study will be concluded during the fiscal year and a report presented to the leadership offices by September 1, 2010. It is anticipated that the findings from the study will provide a basis on which to make recommendations related to structuring, funding, and implementing a pilot program that addresses the services necessary for individuals with ASD to live independently and productively in the community.

H.B. 1574 also mandated the establishment of an ASD resource center for Texas. The purpose of the Texas Autism Research & Resource Center (TARRC) is to provide greater support to individuals with autism and other pervasive developmental disorders and their families. Once created, TARRC and its website will:

- Collect and distribute information and research regarding autism,
- Conduct training and developmental activities for persons who may interact with individuals with autism,
- Coordinate with local entities that provide services to individuals with autism, and
- Provide support to families affected by autism.

## **5.6.2 Regulation, Certification, and Outreach Initiatives**

### **Financial Activities Related to Nursing Facility Licensure**

In addition to the current economic recession, financial problems in the nursing facility (NF) industry continue today. Costs for food, fuel, and other supplies continue to fluctuate. Credit has tightened and the U.S. Internal Revenue Service (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. DADS 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.

Accordingly, gathering financial information via the license application and reviewing financial information is now a part of the standard operating practice related to processing applications for NF licensure. Regulatory Services also uses a financial risk alert system to make a determination as to whether a facility will be considered at a high risk for financial insolvency. This system includes data from various sources within DADS, including:

- Vendor Payment Holds,
- IRS Levies,
- Financial Viability Assessment (from the license application),
- Licensed Bed Occupancy Rate Change,
- Medicaid Bed Occupancy Rate Change, and

- Notices of adverse changes in financial condition.

### **Incentive Payment Program**

The DADS Rider 45 of the 2010-11 GAA and Section 531.912 of H.B. 1218 , 81st Legislature, Regular Session, 2009, direct the Executive Commissioner to establish a quality of care health information exchange with NFs that choose to participate in a program designed to improve the quality of care and services provided to Medicaid recipients. The program may include incentive payments only if money is specifically appropriated for that purpose. DADS has issued a request for proposals (RFP) to assist in the development and implementation of an incentive payment program for NFs in Texas that demonstrate superior performance. The Incentive Payment Program requires the vendor to develop the Incentive Payment Program, conduct NF resident and family satisfaction surveys, and implement the program. An RFP was released on February 16, 2010. Vendor proposals were due April 9, 2010 with an anticipated contract start date of May 5, 2010.

## Chapter 6

# Department of Assistive and Rehabilitative Services External/Internal Assessment

### 6.1 Overview

The Department of Assistive and Rehabilitative Services (DARS) enabling statute is found in the Human Resources Code, Chapter 117. DARS also has numerous statutes for its legacy agencies.

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. Additionally, the Office of the Deputy Commissioner administers the Autism program. Through these program areas, DARS provides services that help Texans with disabilities find jobs through vocational rehabilitation, ensure Texans with disabilities live independently in their communities, and help children with disabilities and developmental delays reach their full potential.

The remainder of this chapter is arranged as follows:

- Mission;
- External Assessment: Challenges and Opportunities, and Planned Actions;
- Internal Assessment;
- Cross-Agency Coordination and Planning Initiatives; and
- DARS Initiatives.

Appendix G includes a description of the agency target populations and service descriptions.

## 6.2 Mission

The mission of DARS is 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.

## 6.3 External Assessment: Challenges and Opportunities, and Planned Actions

### 6.3.1 Evaluating the Early Childhood Intervention Program

The Early Childhood Intervention (ECI) service system in the present form is not sustainable and may not be delivering the benefits to children and families that lessen their dependence on special education and other state services over time. Ensuring that children who have developmental delays enjoy the same opportunities as other Texans to pursue independent and productive lives is an HHS system strategic priority.

Strategic Priority: Create opportunities for increased self-sufficiency and independence.

- Ensure that children who have developmental delays enjoy the same opportunities as other Texans to pursue independent and productive lives.

#### Discussion

Many states are facing significant challenges as they continue to implement early intervention systems operating under Part C of the federal Individuals with Disabilities Education Act (IDEA). The ECI system is required to reach all the children eligible to receive services and provide all of the services they need. However, the system is currently challenged to do this for several reasons:

- Significant growth in the number of children and families receiving services (approximately 7 percent each year)
- Resource levels that do not support adequate service levels
- A complex contract payment structure with multiple federal, state, and local funding sources

## **Planned Actions**

Consequently, DARS is evaluating the ECI program. The goal of this evaluation is to develop recommendations for a sustainable ECI program that can effectively serve children and families. The evaluation will have several components, including:

- Input from parents, pediatricians, and program/clinical experts to identify aspects of the ECI system that are most important to children and families, strengths of the ECI system, and services that are not aligned with the program's priorities and strengths;
- Assess the gap between service needs and ECI service levels;
- Examine family cost share and co-pay policies; and,
- Evaluate and recommend changes to contract and payment structures and methods used to account for funding sources.

DARS conducted eight statewide meetings in January 2010 to allow stakeholders, especially families who have received ECI services, to share their ideas on how the department can most effectively use limited dollars to provide the services most important to children and families. The meetings also provided an opportunity for the public to comment on recommendations for potential changes to ECI eligibility criteria. The latter recommendations were developed by a small, diverse group of stakeholders in December 2008 in the event that there was no increase in funding for the program in the 2010-11 biennium.

In March 2010, DARS ECI contracted with a consultant to prepare a recommendation for a new contract structure and financing strategy for the Early Childhood Intervention program which will promote quality services, effectively use available funds, enhance the ability to access additional revenue and reduce administrative burden for contractors. Through a contractor, DARS will also conduct an analysis of the gap between the services that children and families need and current ECI service levels.

### **6.3.2 Managing Limited Services for Children with Autism**

The Centers for Disease Control and Prevention recently reported that 1 in 97 children in the United States (U.S.) has an autism spectrum disorder.

DARS is committed to ensuring that children with disabilities enjoy the same opportunities as other children to lead independent lives. The DARS Autism Program was developed as a pilot project in fiscal year (FY) 2008 to begin to address the needs of children 3 through 8 years of age with a diagnosis on the autism spectrum. Initially the pilot served two geographic areas of Texas: Houston and Dallas/Ft. Worth. An increase in funding from the 81<sup>st</sup> Legislature allowed the program to expand to two additional geographic areas (Austin and San Antonio); however, services are still not available in many areas of the state. In addition,

current DARS providers indicate they have the capacity to serve additional children in the existing services areas.

Strategic Priority: Create opportunities for increased self-sufficiency and independence.

- Ensure that children who have developmental delays enjoy the same opportunities as other Texans to pursue independent and productive lives.

## **Discussion**

### ***Recent Program Changes***

Several changes were made to Autism Program contracts for the current grant cycle as a product of lessons learned during the first grant cycle. These changes were made to reduce inter-agency discrepancies and make service provision more financially equitable.

### ***Cost Share System***

During the first grant cycle, provider agencies were given flexibility to dictate the amount of parental contribution as well as the cost per child to DARS. In the current grant cycle, two major changes were implemented. First, DARS developed the DARS Autism Program Sliding Scale Fee Schedule, and all programs are required to use this schedule when determining the amount of private pay required for services. Second, per-month cost for services was capped at \$5,000 per child without prior written approval from DARS.

### ***Insurance Billing***

Per their new contract, provider agencies are required to file insurance claims for the total value of an individual child's service on a monthly basis, where the child receiving services is insured under an applicable medical insurance policy. If the services provided are covered in part or in full by insurance, another governmental program, or a private source, provider agencies are required to report this to DARS and apply payments from other sources to the autism services. DARS must be the payer of last resort for all services provided to children under the DARS Autism Program.

### ***Standardized Success Measures***

During the first grant cycle, child success was measured through the tracking of the number of skills attempted and the number of skills mastered by each child on a monthly basis. Review of provider agency data revealed significant differences across provider agencies, due, in part, to definitions of "skill" and criteria for "mastery." These differences made comparisons between provider agencies impractical.

In the current grant cycle, provider agencies are required to administer four standardized measures at three points in time. The four measures include the Peabody Picture Vocabulary Test – 4, the Expressive Vocabulary Test – 2, the Reynolds Intellectual Assessment Scales, and the Pervasive Developmental Disorders Behavior Inventory extended format, and all four have been previously validated and normed. They will be administered to each child upon entry into treatment, after 6 months of treatment, and after one year of treatment. This will provide a standardized measure of progress for each child and allow for inter-child and inter-agency comparisons.

### **Planned Actions**

DARS intends to make progress toward the strategic priority of improving access to services that address the needs of these children through its Autism Program and will continue to explore opportunities for expansion.

## **6.3.3 Improving Direct Service Delivery Program Staffing**

Strategic Priority: Strengthen and support the health and human services workforce.

- Recruit high-quality staff.

Strategic Priority: Deliver the highest quality of customer service.

- Improve agency business practices to create a more coordinated, cost-effective, and customer-friendly service delivery system.

### **Discussion**

Staffing in several critical direct service delivery programs (Vocational Rehabilitation, Independent Living, and Comprehensive Rehabilitation Services) continues to be an issue at DARS. There have been no worker positions added to these programs in 10 years. The management to staff ratio in the Blind Services Division exceeds 1:19 while the State Auditor's Office target is 1:11. And, caseloads in many programs currently exceed maximum levels for quality service delivery. These conditions impede DARS's ability to deliver the highest quality services and place burdens on staff which, over time, will lead to higher turnover.

### **Planned Actions**

DARS will consider alternative ways to deliver services through these programs. For example, to outsource certain important but non-core functions currently performed by DARS direct service staff to increase the effectiveness and efficiency of rehabilitation services.

### **6.3.4 Preparing for a Potential Change in the Federal Vocational Rehabilitation Funding Formula**

A U.S. Government Accountability Office report released in September 2009 suggests a change to the method by which the Vocational Rehabilitation (VR) program is funded.<sup>1</sup> If Congress amends the Rehabilitation Act to include this change to the funding formula, DARS may lose between \$5.1 million and \$14.5 million per year in its VR programs. This loss of funds would be detrimental to the program and may require DARS to submit a request for an Order of Selection to the U.S. Department of Education's Rehabilitation Services Administration (RSA).

Strategic Priority: Create opportunities for increased self-sufficiency and independence.

- Ensure that policies and services encourage employment and individual responsibility.

#### **Discussion**

Under an Order of Selection, DARS would no longer be able to implement services for eligible groups of consumers who would have previously received services. This is, in essence, a narrowing of criteria for who receives services after eligibility has been determined. That means that individuals with a wide variety of diagnoses, such as students and adults with specific learning disabilities, attention deficit disorders, some consumers with amputations, congenital disorders or birth injuries, other physical conditions and some consumers with depressive and other mood disorders, would potentially not receive services because the severity of the disability would not be substantial enough to meet new criteria. This has a ripple effect with business customers as this population is often hired by business in the higher wage jobs. Additionally, narrowing the scope of individuals who could receive services would dramatically decrease or eliminate the Transition Services Program.

#### **Planned Actions**

DARS will monitor reauthorization of the Rehabilitation Act for developments related to the funding formula.

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<sup>1</sup> United States Government Accountability Office. "Vocational Rehabilitation Funding Formula: Options for Improving Equity in State Grants and Considerations for Performance Incentives," Report [GAO-09-798](#), September 2009.

### **6.3.5 Expanding Vocational Rehabilitation Services to Rural Areas**

Ensure that policies and services encourage employment and individual responsibility.

- Strategic Priority: Create opportunities for increased self-sufficiency and independence.

#### **Discussion**

Ongoing challenges exist to provide VR services to Texans in rural areas. These services include limited availability of Community Rehabilitation Program (CRP) services, vocational evaluations, psychological assessments, and other assessments. CRP providers from larger metropolitan areas have attempted to provide services in rural areas, but often find doing so to be cost-prohibitive due to travel expenses. Additionally, some rural areas may not offer a volume of business that providers find suitable or adequate to ensure business survival. In smaller rural areas, for example, a psychologist may only come to test consumers once they are guaranteed to test a certain minimum number. This leads to service delays and is inconsistent with the strategic priority to provide services accurately and on time. In addition, counselors in rural areas are forced to pay the expenses of sending a consumer from home to another city for assessments.

#### **Planned Actions**

DARS has developed and is piloting strategies to encourage providers to travel to rural areas and provide needed services. These involve paying vendors' administrative fees and travel mileage. Additionally, DARS has contracted with the Center for Social Capital to develop staff and CRP expertise in customized self-employment. Self-employment is often an effective strategy for consumers in rural areas where limited hiring opportunities exist. These pilot initiatives will continue through the current biennium.

### **6.3.6 Strengthening the Statewide Network of Centers for Independent Living**

Centers for Independent Living (CILs) play 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 26 CILs in Texas. Stakeholders, including

the Statewide Independent Living Council (SILC), would like continued expansion of the CIL network and increased funding of existing CILs.

Strategic Priority: Create opportunities for increased self-sufficiency and independence.

- Partner with persons with disabilities in overcoming barriers to full participation in the community and the labor market.

## **Discussion**

Independent living services—from early childhood intervention to senior services, from vocational placement to community integration—are an integral part of the continuum of assistance essential to persons with disabilities. These services create opportunities for increased self-sufficiency and independence. CILs 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 people with disabilities live more independently, avoid living in an institution, and where appropriate, obtain employment. CILs have made significant efforts to assist individuals living in institutions to relocate to community living. Serving people with disabilities in the community has been shown to be less expensive than institutional settings.

## **Planned Actions**

DARS will continue to work with SILC and other stakeholders to identify opportunities to strengthen the CIL network.

## **6.4 Internal Assessment**

### **6.4.1 Maintaining and Developing the Workforce**

#### **Succession Planning**

Most organizations expend a great deal of energy to effectively plan for their future products, services, customers, and finances. Few organizations apply these techniques to the real source of ongoing effectiveness—human capital. The DARS succession planning project is designed to ensure the department continues to deliver excellent service by having a workforce with the competencies, attitudes and values needed today and into the future. This process will provide DARS management with accurate, complete, timely and relevant staffing and workforce information for future recruitment, training, retention and related succession planning activities designed to meet needs of consumers today and into the future.

## **6.4.2 Addressing Infrastructure Needs**

The DARS Infrastructure and Development Platform Refresh Information Resources capital project supports the replacement and upgrade of hardware, mobile computing products, and software. Refreshing, replacing, and upgrading miscellaneous hardware and software is essential to the continued support of DARS and its programs. This includes adaptive software necessary for our staff with disabilities to thrive in their positions. Continuous improvement allows DARS to use current technology, which is critical to supporting the agency's mission. The Infrastructure Refresh is an operational, routinely requested and approved capital project.

Also, unique to DARS is the maintenance of the Criss Cole Rehabilitation Center. With the age of the facility, there are numerous maintenance issues and increasing need for more efficiency in space utilization. DARS continues to improve work areas to increase energy efficiency, eliminate safety hazards, and provide increased security.

## **6.4.3 Improving Data Quality and Use**

The DARS Dashboard Report was launched in September 2009. The Dashboard Report serves as a management tool providing a statistical chronicle of verified program performance measures that span all of the DARS administrative and service delivery operations. The Dashboard is available in an easily accessible format and discussed on a monthly basis in executive management meetings. The executive-level Dashboard Report is undergirded by existing detailed service delivery reports published on the DARS intranet and available to all DARS staff. Consisting of key metrics specifically selected to report on DARS progress toward operational outcomes, the Dashboard Report is a decision-support tool that synthesizes DARS operational statistics. DARS is exploring automated options for further evolving the Dashboard Report into a fully robust business intelligence and analytical tool.

DARS has also conceptualized and expects to deploy a prototype electronic Data Book available statewide to DARS employees. Ultimately, the Data Book will be an electronically searchable reference with summary statistics on a broad range of DARS operations. For example, state and federal performance metrics, along with consumer outcomes by Texas County will be available in the Data Book. The Data Book will also link to existing detailed reports and analyses on service delivery and consumer operations.

## **6.4.4 Business Continuity Planning and Emergency Preparedness**

Although DARS is not a primary emergency services agency, the agency is committed to working with the Texas Division of Emergency Management (TDEM), Health and Human Services (HHS) Enterprise agencies, and other Texas Emergency Management Council agencies in preparing for, responding to, and recovering from domestic and international threats, natural disasters, and critical vulnerable infrastructure disruptions that could impact Texas as well as DARS' ability to deliver services. DARS will continue to support the emergency response efforts of HHS partner agencies as per the Memorandum of Agreement among the agencies of the HHS Enterprise Emergency Management Council.

Further, DARS is enhancing the Continuity of Operations capability of the agency through the development of a comprehensive continuity program and standing steering committee comprised of key agency representatives. This program will enhance the capability of DARS, agency divisions, and field offices to provide services during business disruptions and recover from such disruptions. In addition, the program will enhance the agency's ability to coordinate resources to support emergency response and will clearly identify the agency's internal procedures for specific threats such as a pandemic public health disaster.

DARS is also committed to working with the TDEM, the Department of State Health Services (DSHS), and other lead State Emergency Management Council Agencies to enhance the preparedness of Texans through communication with stakeholders and providing review and comment on state and local preparedness and planning efforts.

## **6.5 Cross-Agency Coordination and Planning Initiatives**

### **6.5.1 Strategic Relationship with Workforce System**

The Texas Workforce Investment Council (TWIC) serves as the federal Workforce Investment Act's (WIA) required State Workforce Board in Texas. The DARS Commissioner acts as the Executive Commissioner's designee. TWIC, in collaboration with system partner agencies, including the Health and Human Services Commission (HHSC) and DARS, has developed "Advancing Texas: Strategic Plan for the Texas Workforce Development System FY 2010 to FY 2015," the strategic action plan developed by the Governor on October 23, 2009. 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 the Workforce Investment Act, 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.

## 6.5.2 Medicaid Infrastructure Grant

The DARS Medicaid Infrastructure Grant (MIG) program, in collaboration with the HHSC, is developing the infrastructure for a comprehensive system of competitive employment support for people with disabilities.

The primary purpose is to identify and create sustainable competitive employment opportunities through the following goals:

- Increase participation in Medicaid Buy-In (MBI)
- Conduct mapping and analysis of system services
- Continue partner collaboration
- Sustain and improve efforts to inform consumer and employer base

The DARS MIG staff developed and launched the Employment & Disability Connections website in 2009, designed for job seekers, business, and service providers and professionals ([www.dars.state.tx.us/edc](http://www.dars.state.tx.us/edc)). MBI outreach services are provided by contracting with Work Incentive Planning Assistance Programs which also provide education and outreach efforts on work incentive eligibility, benefits planning, and employment. The MIG Advisory Committee facilitates collaboration between HHSC enterprise and other public-and-private-sector partners to develop and implement strategies to improve employment supports for Texans with disabilities.

The Centers for Medicare & Medicaid Services have funded the DARS Medicaid Infrastructure Grant at the following levels:

<u>Fiscal Year</u>	<u>Amount</u>
2008	\$500,000
2009	750,000
2010	<u>750,000</u>
<b>Total</b>	<b>\$2,000,000</b>

### **6.5.3 Memorandum of Agreement with Department of Veterans Affairs**

The U.S. Department of Veterans Affairs (VA) estimates the total number of veterans in the country to be 23,067,000.<sup>2</sup> Military veterans returning to Texas from duty overseas represent a population that may benefit from increased access to programs at DARS. Historically, the department has had a memorandum of agreement (MOA) with the VA-Vocational Rehabilitation and Employment Services (VA-VRE) program. The objective of this MOA was to coordinate VR and independent living services with those provided by VA-VRE to maximize services and improve outcomes.

Currently, DARS is revising the MOA, which is expected to be finalized before the end of FY 2010, to include a focus on coordination of services to veterans with traumatic brain injury (TBI) and traumatic spinal cord injury (SCI) in addition to traditional VR services. DARS provides TBI and SCI assistance under its Comprehensive Rehabilitation Services (CRS) program, through contracts with independent providers around the state. VA-VRE provides similar services, but in more limited geographic areas. The MOA sets forth the framework each agency will follow in order to provide a clear understanding of services provided by each agency, methodology for making referrals and sharing information between agencies, and system for coordinating services available from each agency. Eligible veterans may also receive additional services through the DARS CRS program when those services are unavailable through VA-VRE.

Veterans with traumatic brain injury and spinal cord injury seek CRS services in very small numbers. Over the last eight years, five to seven percent of consumers in the CRS program have been veterans. Although this percentage has not been increasing, recent projections suggest a rise in the number of veterans diagnosed with TBI and SCI.

### **6.5.4 Supported Employment**

Supported Employment is competitive employment in an integrated work setting for consumers with the most significant disabilities who need extended services (at or away from the worksite) to maintain employment following VR closure.

The Rehabilitation Services unit and the Blind Services (DBS) unit have implemented an Outcome-Based Supported Employment process, which includes standardized forms, policy and quality criteria to ensure quality performance by providers. A key component of the Outcome-Based Payment System for Supported Employment is the emphasis on using naturally occurring work supports and linking

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<sup>2</sup> United States Department of Veterans Affairs, Office of Policy and Planning, [National Center for Veterans Analysis and Statistics](#), February 01, 2010.

consumers with long-term extended service providers who will assist the consumer maintain employment.

Collaboration is the key to successful long-term employment outcomes. DARS partners with community organizations and with other state agencies providing direct services related to long-term Supported Employment Services for persons with disabilities. Potential funding sources include Medicaid waivers, Social Security work incentives, DSHS, Department on Aging and Disabilities (DADS) and a variety of local community sponsorships. DARS has an MOA with DADS identifying the roles of each agency in the provision of Supported Employment Services to consumers with intellectual and developmental disabilities. DARS is also partnering with DSHS' Division of Mental Health and Substance Abuse through local Learning Communities to improve the coordination of Supported Employment Services for individuals with severe mental illness.

### **6.5.5 Transition Services to Youth**

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 101 positions dedicated to serving only 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. In Texas, 7,968 students were served during FY 2009.

Pursuant to House Bill 1230, 80<sup>th</sup> Legislature, Regular Session, 2007, DARS developed an expanded training program for TVRCs, which includes quarterly regional training forums coupled with a DVD and "Guide to Transition" provided to each TVRC. The DVD features experts from numerous state agencies who would not otherwise be able to attend multiple training sessions, covering strategies on building relationships with service providers to meet consumer needs, supports and services available from other state agencies and community resources, and advice on matching transitioning consumer needs with available resources. The face-to-face training forums supplement the DVD with region-specific resources, information and tools to address local issues. This training is a permanent feature in DARS's overall training curriculum and employees are eligible to receive Continuing Education Units upon completion. In addition, all TVRCs have access and contribute to a website called Texas Transition Talk, which contains a wide variety of resources for TVRCs and transitioning students and is continually updated as new materials are added.

## 6.6 DARS Initiatives

### 6.6.1 Support Service Providers for the Deafblind

People who are deafblind face vision and hearing challenges in all aspects of everyday life. Because communication and mobility are the two areas most affected by a loss of sight and hearing, people with dual sensory loss must find ways to communicate, navigate their surroundings, and find social, living and employment situations that fit their individual needs and abilities. A critical need for this population is reliable, skilled Support Service Providers (SSPs). SSPs relay visual and environmental information, help with mobility and access to transportation, and facilitate communication for people who are deafblind. They also help reduce communication barriers that could otherwise result in unemployment, underemployment, social isolation, inability to participate within the community, and in some instances, institutionalization. SSPs do not fill the roles of personal care attendants, sign language interpreters, or caregivers. While the development and support of SSP services is gaining momentum throughout the nation, there are no programs that provide SSP services in Texas. Further, although SSP services are highly valued in the deafblind community, SSPs are not universally recognized as a profession. Additionally, no state or national certifications, licensures, or credentials exist for SSPs. In Texas, SSPs are arranged informally, and typically, on a volunteer basis.

Currently, the DBS Deafblind Services Unit offers a variety of services to help consumers who are deafblind find or maintain employment and live as independently as possible. However, these do not include SSP services. If additional funding is made available, DARS may begin purchasing SSP services statewide for consumers who are on a VR or independent living caseload. The deafblind will have an ongoing need for SSP services after provision of VR services is completed. DARS also supports the development of a community-based pilot. If funding is available, it may be possible to identify and collaborate with organizations that could develop and provide SSP services in Texas.

### 6.6.2 Certification for Deafblind Interpreting

People who are deafblind also lack sign language interpreters who are skilled in the various modes of communication used by people who are deafblind. For example, if a deaf person who uses sign language for communication becomes blind, that person would shift to a tactile mode of sign language. To respond to this need, DARS is exploring the development of a specialty certificate in deafblind interpreting, as a part of the DARS Deaf and Hard of Hearing Services unit's current sign language interpreter certification program. This would include the creation of valid and reliable tests and scoring mechanisms, as well as payment of specialized interpreters to score the tests. Additionally, DARS would like to foster the

development of a statewide provider base of sign language interpreters with these specialized skills by offering a series of interpreter training programs in locations across the state. DARS would require additional funding to accomplish these initiatives.

### **6.6.3 Start-Up Funding for the Supportive Opportunities for At-Risk Students Program**

The need for the Supportive Opportunities for At-Risk Students (SOARS) program continues at community colleges. SOARS is a pilot project at the Southwest Collegiate Institute for the Deaf and is the only community college program in Texas that provides specialized services to students who are at-risk/low-functioning deaf. The project targets students with borderline academic preparedness and limited job readiness and provides tutoring, independent living training, and counseling. Students who have limitations have difficulty learning and need support services tend to drop out without being identified. According to a Gallaudet University article published in 1994, half of the seventeen- and eighteen-year-old deaf and hard-of-hearing students left special education programs reading below the fourth grade level. Providing start-up funding in mainstream community colleges for SOARS would assist in appropriately identifying this target population and give the support needed to students.

To respond to this need, DARS is evaluating funding strategies, including an add-on fee for VR consumers, to increase the number of students who can benefit from this program.

### **6.6.4 Contracting for Certain Services**

Contracting for certain services and additional supports creates opportunities to clear time for VR Counselors and Rehabilitation Service Technicians from using time on non-core services and improve efficiency and the rehabilitation rate. Additionally, some tasks may be handled more successfully by contracting services since they would have more time to devote to the function and specialize in specific areas.

Non-core services are those services not required by statute to be provided by counselors or staff in direct support of counselor functions, but are nonetheless deemed important to service effectiveness, consumer retention and improved successful closure rates. Examples of services for which contracts could be developed include switchboard functions, appointment reminder calls, and customer satisfaction calls.

DARS is piloting customer service calls through a contract with a call center. Call centers will make reminder calls to at-risk consumers, as well as follow-up calls after appointments to determine quality of services provided. The department will use this

pilot to determine appropriate next steps in an effort to continue to employ innovative practices for long-term solutions.

# Chapter 7

## Department of Family and Protective Services

### External/Internal Assessment

#### 7.1 Overview

The Texas Department of Family and Protective Services (DFPS) was created with the passage of House Bill 2292 by 78<sup>th</sup> Legislature, Regular Session. Previously called the Texas Department of Protective and Regulatory Services, DFPS is charged with protecting children, adults who have disabilities or are elderly from abuse, neglect, and exploitation. DFPS also ensures child safety and well-being by licensing day-care and residential operations. As part of its work, the agency manages community-based programs that prevent delinquency, abuse, and neglect of Texas children.

The agency's services are provided through its Adult Protective Services, Child Protective Services, and Child Care Licensing divisions. Prevention and Early Intervention is administered as part of Child Protective Services. Every day, approximately 11,000 DFPS employees in more than 300 offices across the state protect the physical safety and emotional well-being of the most vulnerable Texans.

DFPS has responsibility for the following efforts, presented here in the order in which they appear in the 2010-11 General Appropriations Act (GAA) (S.B. 1, 81<sup>st</sup> Legislature, Regular Session, 2009):

- Statewide Intake Services,
- Child Protective Services,
- Prevention Programs,
- Adult Protective Services, and
- Child Care Regulation.

The material in this chapter is arranged as follows:

- Mission;
- External Assessment: Challenges and Opportunities, and Planned Actions;
- Internal Assessment; and
- DFPS Initiatives.

Appendix F includes a description of the agency target populations and service descriptions.

## 7.2 Mission

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

## 7.3 External Assessment: Challenges and Opportunities, and Planned Actions

As outlined above, DFPS serves Texans of all ages in a variety of ways, helping to implement all of the Health and Human Services Strategic Priorities:

- Deliver the highest quality of customer service,
- Improve the health and well-being of Texans,
- Create opportunities for increased self-sufficiency and independence,
- Protect vulnerable Texans from abuse, neglect, and exploitation,
- Encourage partnerships and community involvement, and
- Strengthen and support the health and human services workforce.

Given its mission, DFPS has an especially strong role in ensuring Texans' protection from abuse, neglect, and exploitation. Client safety is always our first priority. As the population of Texas continues to grow and to age, DFPS will be challenged to meet the needs of Texans across all its programs. Over the next decade we expect to experience an ever-increasing rate of growth in the demand for our services. In addition to this primary focus, DFPS programs also support the other Strategic Priorities, weaving these values into all our work. Outlined below are the significant challenges DFPS expects to encounter in the Strategic Planning period of 2011-15, and the opportunities that DFPS is taking to address the challenges.

### 7.3.1 Improving Child Protective Services Capacity

When a child is at risk at home, Child Protective Services (CPS) takes all reasonable measures to ensure the safety of the child, first and foremost, while also supporting the integrity of the family and its ability to care for the child. There are several stages of services that CPS can provide, depending on a child's circumstances.

Along this spectrum, CPS caseworkers serve children with a wide variety of services.

Strategic Priority: Deliver the highest quality of customer service.

- Improve agency business practices to create a more coordinated, cost-effective, and customer-friendly service delivery system.

Strategic Priority: Improve the health and well-being of Texans.

- Improve access to services that address behavioral health needs.
- Provide an outcome-based, quality-oriented system of care.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Improve our ability to detect potential risk to vulnerable children and adults in the community.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with families, stakeholders, community organizations, providers, and others in the public to address service delivery issues and ensure customers receive timely, appropriate services.

## **Discussion**

### ***Services to Families***

Even in an unsafe home, removing children from their family may not be the only solution. It may be that extended family exist, or other adults with close connections, that would be willing and able to provide care in a safe environment. To acknowledge this reality and benefit from the strength in the community, CPS formed the Family Focus Division and now includes more families in safety planning and decision-making. Children who may have been removed from the home five years ago are now being served within the family as the family-focused approaches have led to more family-friendly solutions to immediate safety issues.

Through Family Based Safety Services (FBSS) and other family-centered practices, parents are more involved in deciding where their children will be placed, for example, in informal living arrangements outside the home with protective relatives or close family friends that are not court supervised. When a child is being served in this way, the child's caseworker must support service delivery to the child's original home and to the new location for the child. When there is more than one child in the home, sometimes all the children cannot be accommodated in a single location, and then the caseworker has three or more homes to serve for one family.

The number of families served by FBSS has grown by nearly 50 percent in the past three years. In response, the 81<sup>st</sup> Legislature allocated additional FTEs to the FBSS program and this measure has allowed CPS to support more children in family placements. To ensure safety and minimize risk, more resources will be required to sustain the anticipated continued growth of these services.

### ***Conservatorship***

Even as CPS has been serving more children in the family context, there has been an increase in the number of children who must for their safety be removed from their homes. These children must be placed in substitute care, in the conservatorship of CPS.

Initially, they are placed in temporary managing conservatorship, while CPS evaluates the family's situation and the parents' commitment to care for the children. The family and CPS then have 12 months within which to achieve legal resolution of a child's case. Much work must be done to find the best placement for that child and to attempt to repair the family: kinship assessments and home studies, psychological evaluations, therapeutic services for children and families, parenting classes, substance abuse counseling, substance abuse testing, home studies, and increased need for specialized placements. Many of these services are court ordered, and their affordability and statewide availability are difficult challenges facing the CPS program as it tries to serve the children in its custody.

The demands of the new cases, with the legal deadlines looming, compete for attention with the demands of children whose legal case has achieved resolution, as the same workforce is serving both these stages of service. Subsequently, an increase in the number of children waiting adoption may occur.

### ***Placements Close to Family and Services Needed***

The child welfare system in Texas has long faced the challenge of having a high percentage of children in foster care placed outside of their home community. The resources for serving these children in foster care are concentrated in specific areas of the state, while being virtually non-existent in others. Also, there is a lack of continuum of care among residential provider types that has impacted the location of placement resources. As of August 2009:

- 16.9 percent of children in foster care were placed out of their home region,
- 57.8 percent of children were placed out of their home county, and
- 20.3 percent of sibling groups were not placed together.

On average, children in foster care experience four moves while in CPS care.

These moves can cause stress in children's lives in a variety of ways: separation from siblings; disrupted connection from extended family, friends, and community; and changes in schools, therapists, doctors, and other care providers.

### **Planned Actions**

#### ***Fostering Connections***

Workloads for DFPS Foster and Adoptive Home Development staff will increase along with the increased number of children being removed from their homes.

Implementation of the Permanency Care Assistance Program, of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (H.R. 6893), also referred to as Fostering Connections, will make possible additional permanent placement options for children in the managing conservatorship of CPS through verification of relative caregivers to become foster parents.

The ultimate goal is for the relative caregivers to take Permanent Managing Conservatorship after six months of fostering the child. At this point they become eligible to receive Permanency Care Assistance (PCA) funding until the child reaches adulthood. Funding for the PCA will be available in October 2010. Over time this program will assist in reducing the numbers of children in CPS conservatorship and create permanent homes with family rather than having children grow up in, and age out of, foster care.

Increasing numbers of children coming into CPS conservatorship and increasing numbers of relatives interested in PCA require staff to increase the number of CPS pre-service training sessions and/or strengthen the collaboration with private Child Placing Agencies in order to meet the growing capacity needs.

### ***Improving Child/Youth Placement Outcomes: A System Redesign***

Over the past several years, DFPS has engaged in numerous internal and external initiatives to address challenges associated with foster care capacity. The assessment of each initiative has resulted in similar recommendations calling for the need to evaluate and modify Texas foster care procurement, as well as examine the current methods for contracting services and foster care payment methodologies.

To address this persistent concern, DFPS has undertaken a major new project called "Improving Child/Youth Placement Outcomes: A System Redesign." Part of this project includes simulation model testing to allow DFPS and its provider community to test operational strategies for foster care under different assumptions and conditions. The results will help determine which conditions lead to sustainable, appropriate, and least restrictive placement resources, as close to the children's home communities as possible.

Every entity that touches the life of a child in the system must be considered in the redesign process. DFPS is committed to involving stakeholders at every stage of the project and to providing project updates through various outlets, including the agency public website, presentations, and stakeholder meetings.

Designing a system to improve outcomes for all children and youth in foster care in Texas is a highly complex task, and DFPS has set an ambitious goal of finalizing the implementation plan for redesign by January 2011. The following are potential obstacles:

- Designing a system that is functional for the state as a whole and applicable to meeting local needs as well;

- Ensuring that communities have the local service provider infrastructure in place to meet the needs of the children/youth; and
- Obtaining accurate, relevant information to enable the project's success.

### ***Reducing Disproportionality of Outcomes for Children***

The redesign of the foster care system is particularly important for African-American children and their families because they are disproportionately represented in the CPS foster care system, not only in Texas but nationally also.

In Texas in fiscal year (FY) 2009, African-American children made up only 11.8 percent of the child population; by contrast, they were 27.9 percent of all children removed from their homes, and 34.8 percent of all children waiting for adoption. These disparities exist even though there is no difference in abuse or neglect substantiation rates among racial or ethnic groups in Texas.

DFPS is continuing its commitment to reducing the disproportionate representation of African-American children in the CPS foster care system. In addition, DFPS will move forward with a closer examination of disparities in the CPS system for Hispanic children and their families.

## **7.3.2 Ensuring Adult Protective Services as Safety Net**

Adult Protective Services (APS) is often the only available option for many individuals. When adults are elderly or have disabilities, they sometimes fall through the cracks in families and communities, and when they do, APS is available to provide a safety net: care coordination and, in some cases, funding the services that are necessary to return the individual to a state of protection.

Strategic Priority: Create opportunities for increased self-sufficiency and independence.

- Assist older Texans and those with disabilities to gain, maintain, and enhance their ability to function independently.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Ensure the safety and well-being of Texans in state-operated and contracted residential facilities, as well as those provided services in their homes.
- Improve our ability to detect potential risk to vulnerable children and adults in the community.
- Ensure that licensing and regulatory authorities hold public and private sector providers accountable for the health and safety of clients.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with families, stakeholders, community organizations, providers, and others in the public to address service delivery issues and ensure customers receive timely, appropriate services.

## **Discussion**

### ***Population Growth***

The Texas State Data Center estimates the baby-boomers will generate a 200 percent increase in the number of persons over age 65, between 2010 and 2040. This sharp increase in the elderly population will result in an extraordinary demand for APS services. The existing infrastructure for community-based long-term care and services will not be able to meet the future needs of a growing elderly population without substantial additional investment. Adequate infrastructure is necessary to provide ongoing support to clients after short-term interventions by APS.

As the number of clients for APS increases, so will the demands on the time and budgets of APS workers. The specific challenges that face the APS client population include the recidivistic cases which cannot be resolved. These instances include clients who live with severe physical impairments, mental illness, and dementia, many of whom also live in extreme poverty.

APS intervention cannot resolve the root causes of poverty, mental illness, or progressive dementia, and it is expected that many clients with these issues will continue to have an ongoing need for APS to serve as their safety net.

### ***Need for Long-Term Solutions***

Many APS clients have fallen into a state of abuse, neglect, and exploitation because other social services programs have exhausted funding, eliminated or reduced services, have lengthy waiting lists, or the individual does not fit in the eligibility categories of other existing programs. APS is authorized to fund short-term emergency social services, not ongoing services.

Many referrals to APS are due to a lack of a consistent continuum of care, causing elderly persons and adults with disabilities to repeatedly require short-term, emergency assistance from APS. In 2009, more than 14 percent of APS reports assigned for investigation were for clients who had previously been referred to APS.

To better serve older adults and adults with disabilities, there needs to be an increased state-wide focus on affordable housing, basic needs such as food and utilities, and more affordable supportive living environments such as Home and Community-Based Services (HCS) homes and assisted living centers. These housing arrangements would provide a more stable environment for older adults and people with disabilities.

## **Planned Actions**

### ***Reform Evaluation***

To assess whether the program is operating as effectively and efficiently as it can, APS conducted an evaluation of the APS reform measures implemented over the past several years. The evaluation report contains a number of recommendations that would improve the program's ability to serve as an effective safety net. It recommends that APS:

- Review policy efficacy to ensure caseworkers spend their time on value-added case work activities;
- Support caseworkers and supervisors by improving recruitment and retention efforts;
- Examine client assessment data and service delivery data together to identify ways to ensure better client outcomes;
- Consider evaluating the effectiveness of the recently-implemented special processes to improve investigations and developing best practices in investigations; and
- Improve the collection and use of client outcome and performance data.

APS is now engaging field staff to review, prioritize and develop implementation plans for the recommendations, with the goal of improving the safety net for vulnerable Texans. This effort will continue through FY 2010 and into FY 2011 as necessary.

### ***Community Engagement Efforts***

APS collaborates, at both the state and local level, with a wide variety of partners, including civic and non-profit providers, financial institutions, law enforcement agencies, other service provider agencies, universities, and faith-based organizations. These collaborations enhance the social safety net by strengthening community resources for clients. Ongoing APS community engagement efforts will support the safety net for vulnerable Texans by:

- Supporting and expanding the resources available from local boards and coalitions and the statewide Texas Partners for Adult Protective Services;
- Continuing to support special task units in counties with populations of 250,000 or more, which provide support for complex APS cases by engaging other disciplines to effectively solve problems, identify resources, make recommendations on cases, and serve as catalysts for additional services from the local community; and
- Implementing local community engagement plans that address the findings of the APS community satisfaction survey.

### **7.3.3 Addressing Capacity Needs of Statewide Intake Services**

The challenges to meet increasing demands will come not only at the point of direct delivery of services but across the spectrum of support systems that enable the agency to operate and meet the needs of its clients. This includes the Statewide Intake Program (SWI). SWI takes reports on abuse, neglect, and exploitation of children, elderly persons, or adults with disabilities. Reports of abuse, neglect, and exploitation of children, the elderly, and adults with disabilities will increase in accordance with the size and demographics of the population.

Strategic Priority: Deliver the highest quality of customer service.

- Improve agency business practices to create a more coordinated, cost-effective, and customer-friendly service delivery system.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Improve our ability to detect potential risk to vulnerable children and adults in the community.

Strategic Priority: Strengthen and support the health and human services workforce.

- Recruit high-quality staff.
- Recognize and reward employee performance.

## **Discussion**

### ***Workforce***

SWI operates 365 days per year, twenty-four hours per day. In addition to phone calls, SWI receives faxes, letters, and Internet reports that are reviewed, assessed and entered into the DFPS automation system by an intake worker for assignment to local caseworkers. Intake workers need to be continually hired and trained to accept reports in a professional manner and accurately process the reports in an expeditious manner.

### ***Technology***

In addition to needing a growing workforce that is highly trained and competent, SWI must also have communication technology that can meet the system's demand. The current Automated Call Distributor (ACD) system will reach its capacity in the near future and will require upgrades to its support systems in order to handle the load increases expected over the next few years. Failure to provide such expansion will jeopardize the ability of SWI to maintain hold times to current levels and may lead to increases in hold times. The ACD core and support systems were purchased four years ago. The ACD core life expectancy is about 12 years before replacement is

required. But, the support systems are server-based and require constant updating and expansion. The life expectancy of these support systems is five years.

## **Planned Actions**

### ***Continuity of Operations***

Statewide Intake is implementing the use of VoIP (Voice over Internet Provider) phones loaded on laptops to enable staff to work offsite and take calls during business continuity situations, such as weather-related events, disaster recovery events, or social distancing occurrences. This new system is expected to be fully implemented by November 2010. If proven successful, it will be offered on an ongoing basis thereafter.

### ***System Maintenance***

System capacity expansion to the ACD and call recording system, along with more licenses will be needed to maintain functionality and handle anticipated increases in call volume. The current plan is to attempt to achieve this within current funding during FY 2011 and push replacement out beyond the years addressed by this plan and into future funding cycles.

## **7.3.4 Setting Standards for Child Care Licensing**

Child Care Licensing (CCL) is statutorily mandated to review all rules and standards every six years. Child day care advocates point out that the baseline of care in Texas, set by the rules and minimum standards, is not in keeping with current research on quality care for children younger than five years of age. However, the costs associated with increasing minimum standard requirements to improve the quality of care are generally passed on to the consumer. Increased costs can price parents out of the regulated care market and can cause some to seek less costly unregulated care.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Ensure that licensing and regulatory authorities hold public and private sector providers accountable for the health and safety of clients.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with families, stakeholders, community organizations, providers, and others in the public to address service delivery issues and ensure customers receive timely, appropriate services.

## **Discussion**

CCL is sensitive to the concerns of stakeholders; however, research has shown that a lack of regulatory oversight presents a greater risk to children's health and safety

in out-of-home care. Therefore, recommendations from stakeholders for changes to improve the quality of care must be weighed against the potential impact on child care operators, the affordability and availability of care, and the risk to children placed in unregulated care.

A similar challenge holds true for residential child care operations that are continually adapting their programs to meet the complex needs of children. Stakeholders want to ensure minimum standards do not present a barrier to their ability to serve children or opportunities for children to have "normal" childhood experiences, which often include activities that are typically considered a risk to children in group care settings.

The expected growth of the state's population presents a continuing challenge to CCL for capacity, quality, and affordability of child care. It is important that CCL ensures stakeholder participation in the process of identifying licensing outcomes for children in out-of-home care and use these as guiding principles when proposing rule and standard changes. Resources must be available and focused on the protections offered by regulated care.

## **Planned Actions**

### ***Review of Minimum Standards***

CCL proposes rule changes to the DFPS Council at its quarterly meetings based on legislative requirements, staff recommendations, and stakeholder input. The Council meetings are open to receive public testimony regarding proposed rule changes. At the Council's recommendation and upon approval of the HHSC Executive Commissioner, DFPS published the rules in the Texas Register for formal public comment. CCL will then consider the comments received, make any necessary changes, and propose the final rules for adoption.

CCL is currently reviewing minimum standards, as required by statute, for child day care centers and child day care homes. CCL is also creating a new set of minimum standards for school-age programs and for child care operations located in temporary shelters, as required by Senate Bill (S.B.) 68, 81<sup>st</sup> Legislature, Regular Session, 2009. Stakeholder involvement has been, and will continue to be, a critical and essential part of this process.

Proposed rules and rule changes were brought before the DFPS Council on April 20, 2010, with a request that they be published in the Texas Register for public comment. There was much interest shown and much testimony provided by consumers of child-care, owners and operators of child care operations, and advocate groups. The proposed rules moving forward are expected to be published in the Texas Register and available for a thirty day public comment period in the summer of 2010. Comments will be taken via online submission, email, and standard mail. Notification of the comment period will be disseminated to providers via standard mail postcards, email, and on the DFPS website.

If there are no significant changes to rules or rule changes as a result of public comments, then the complete rules package would become effective by October 2010. If there are significant changes needed to the proposed rules and rule changes based on public comments received, CCL will make changes and re-propose the rules by October 2010, and there would be another public comment period in which the rules would be published for adoption and become effective in January 2011.

### ***Public and Stakeholder Input and Recommendations***

CCL created an electronic comment web-form to post on its public and provider website in order to provide another means for the public and stakeholders to provide comments regarding proposed rules. CCL posts proposed rules and rules changes on its website as another means of making the available and accessible for those participating in the review and comment process. CCL maintains dedicated email boxes year round to receive input from stakeholders. CCL continually reaches out to stakeholders to seek input, particularly around training needs for staff.

The 80<sup>th</sup> Legislature created the Committee on Licensing Standards to make recommendations to the Legislature and DFPS for policy and statutory changes relating to licensing standards and facility inspections. The Committee submits an annual report of recommendations to Legislative leadership and DFPS. The next report is due December 2010.

## **7.3.5 Ensuring Due Process Rights**

In order to protect children and vulnerable adults, there has been growing public policy emphasis on sharing information about perpetrators of abuse, neglect, or exploitation with private employers, other governmental agencies, and even across state lines. However, when sharing information deprives the perpetrator of a protected liberty or property interest, such as employment, there are constitutional requirements to offer a due process hearing. Agency resources have not kept pace with demands, resulting in a significant backlog in pending hearings.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Ensure the safety and well-being of Texans in state-operated and contracted residential facilities, as well as those provided services in their homes.
- Improve our ability to detect potential risk to vulnerable children and adults in the community.
- Ensure that licensing and regulatory authorities hold public and private sector providers accountable for the health and safety of clients.

## **Discussion**

### ***Hearings Currently Offered***

DFPS currently offers a hearing following an administrative review for:

- Persons found by Child Care Licensing to have committed abuse or neglect in a child-care facility, and
- Employees of long-term care facilities who are found by Adult Protective Services to be perpetrators and who are subject to listing on the Employee Misconduct Registry (EMR).

DFPS does not offer a hearing to perpetrators in the CPS program, or to APS perpetrators not subject to the EMR, unless and until the department must share the perpetrator's information outside the department, usually for the purpose of mandatory employment background checks for people in the child-care industry.

Under current law and agency rules, a person found by CPS to have abused or neglected a child must be listed in the Central Registry, which is a confidential database of designated perpetrators. A designated perpetrator is entitled to request an informal administrative review of the investigative finding, and may seek a further review by the department's Office of Consumer Affairs; however, neither of these reviews provides the type of due process hearing that would be required by the Texas or United States (U.S.) Constitutions before deprivation of a person's constitutionally protected property or liberty interests.

Findings are not typically released pending the outcome of the hearing, which may not occur until several years after a person first begins working with a vulnerable population. At the end of December 2009, there were 2,219 pending CCL-related cases, roughly half of which had been awaiting a hearing for more than a year, and one quarter of which had been awaiting a hearing for more than two years.

### ***Expansion of Process***

In 2009, the Legislature added state supported living centers and state hospitals to the list of employees subject to the EMR. This will cause further strain on the process, and no additional resources were appropriated to DFPS to handle the anticipated growth in hearings.

Any delay in releasing an abuse/neglect finding to a child-care employer or other third party who controls the perpetrator's access to children creates some level of risk to children pending the outcome of the due process hearing. There is often a delay of many years between the original finding of abuse/neglect and the triggering event that necessitates the release of that finding and a due process hearing.

Children and vulnerable adults are left unprotected when DFPS is unable to timely share perpetrator information. Moreover, both DFPS and the designated perpetrator are at a disadvantage in presenting their case when the hearing does not take place

until many years after the finding was made. A recent Court of Appeals ruling was critical of the current process for challenging CPS findings and strongly encouraged the department and/or the legislature to change current rules to provide due process up front. As noted in the ruling, both the department and the designated perpetrator may be disadvantaged by the passage of time, as evidence is lost and memories fade.

Over the last several biennia there has been legislative interest in expanding the use of CPS findings to bar employment in other work settings, including public schools. There is also a federal mandate to create a National Child Abuse Registry to promote releases of perpetrator status across state lines, although the timing of implementation for such a registry is likely still many years away, and it is not yet known whether the national registry will be used for employment screenings. Without appropriate staffing and resources, the agency will be challenged to deal with any expansion of the use of this information without severely exacerbating the ongoing problem of timeliness of the process.

## **Planned Actions**

### ***Seeking Appropriate Resources***

DFPS plans to include a Client Safety exceptional item in its Legislative Appropriations Request, which will include, in part, the resources to address the due process challenge. Should the 82<sup>nd</sup> or a subsequent Legislature provide funding for this request, additional attorneys would be hired to prepare and expedite cases. The acquisition of appropriate resources would allow an examination of the current process and an opportunity to move to an up-front process as has been recommended.

## **7.4 Internal Assessment**

### **7.4.1 Maintaining and Developing the Workforce: Employee Retention**

As the development of a high-quality workforce remains one of the largest challenges to the delivery of quality services to clients, DFPS is always striving to improve workforce retention. During the 2008-09 biennium, DFPS undertook the Workforce Support and Retention Initiative (WSRI) as a comprehensive effort to capitalize on retention-related activities occurring in different areas and programs around the state. The initiative was created in response to the Legislature's directive to produce the Human Resources Management Plan.

More than 100 people were involved in the WSRI. People from across the agency and across the state worked on the projects within the initiative. DFPS employees saw a commitment from agency leadership to reduce turnover and make the work environment better for employees.

Turnover measures at DFPS have been improving since the annual turnover rate reached 21.2 percent in FY 2007. The agency's turnover rate decreased from 19.4 percent in FY 2008 to 15.2 percent in FY 2009.

Certainly the national economic downturn has helped employee retention at DFPS. However, the changes in the overall employee turnover rate and the turnover measures in each program are encouraging.

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.

Since it appears DFPS is on the right track regarding turnover, the work of the WSRI can be streamlined. Some staff involved with the initiative will be transitioned into new roles as supervisor support analysts. By providing better support to supervisors, those supervisors will be able to provide better support to their employees.

## **7.4.2 Addressing Infrastructure Demands on the Agency**

Technological advancements are providing an opportunity for DFPS to transition to a direct delivery workforce that is increasingly mobile. This creates the need to review office space needs and how to safeguard information systems as the technology evolves.

### ***Use of Mobile Technology***

The increased numbers of staff using tablet computers has led to new workload models and approaches to casework. Our workforce can spend more time with clients rather than driving back and forth to the office throughout the work day. The traditional workload model is built around office-based technology and the need for frequent returns to the office to document case actions, confer on casework decisions, and meet with clients. That can change as the technology becomes mobile.

A review of industry standards for mobile staff reflects the need for less dedicated individual office space. However, there is a need for more storage space, interview rooms, and reconfigured common space to allow temporary work stations and access to office machines such as copiers and printers. A more mobile staff does

not necessarily result in a reduction of total office space required but rather a change in how space is used.

### ***Information Security***

Safeguarding the technology infrastructure of the agency is and will continue to be an issue of the highest priority. Government computer networks are experiencing an extraordinary increase in the number and severity of security attacks. These attacks use new and sophisticated tools that exploit vulnerabilities in commercial software as well as social engineering techniques. Successful attacks could result in security breaches, network shutdowns, or corruption of important data. DFPS is a year-round, around-the-clock operation that supports a hotline for reports of abuse and an on-call investigative field staff that handle life-threatening emergencies. The availability of network resources and the integrity of information stored is a mission-critical goal.

New frontiers for vulnerability lie in social networking and mobile technology. Social networking systems provide collaboration, investigation, and public information forums that enhance the productivity of DFPS programs. More than half of the workforce at DFPS is mobile. To provide the tools to support frontline caseworker staff and public information campaigns, security strategies must balance need and risk as new challenges emerge.

All state agencies face threats from outside intrusion by individuals or organizations that have an agenda against government or simply have a desire to cause mischief. State agencies face challenges in providing the latest tools to their user community who are increasingly familiar with new technologies while balancing availability and use with the proper security protocols. Making the right decisions requires a logical evaluation of what could happen and therefore is always a difficult projection.

### ***Mobile Caseworker Expansion***

Office space reconfiguration is phased in as numbers of mobile staff increase. Initially changes are minimal, and over time, as new space is acquired, mobile units will be the first to move. New space for mobile staff is configured at a three-to-one ratio, meaning each office or cubicle is configured to accommodate three workers instead of one.

A new Mobile Caseworker (MCW) Expansion project is underway. This project includes the following components:

- Increasing participation in Mobile Casework model by 600 staff—New MCW staff will be proportionally distributed between APS, CPS and CCL (100 APS, 470 CPS and 30 CCL);
- Choosing units in regions that do not currently have MCW Regions—Regions 1, 4, 5, 6, 7 and 10;
- Working with regional management to identify units in areas with known space issues or anticipated lease changes—To address future space

- requirements, and as DFPS acquires new or renegotiated leases, designated mobile units would be assigned to reconfigured new space; and
- Creating a training module, specifically for incoming mobile workers and managers.

Expected rollout of this new MCW phase is October 2010.

### ***Data Security Efforts***

The DFPS network is protected by tools and software under DFPS control, but the entire network connects to a much larger statewide system managed by the Department of Information Resources (DIR). DFPS participates with DIR in the planning and implementation of a shared approach for perimeter security and the sharing of information regarding new threats, especially those that target government networks.

New network tools are being installed by DFPS to provide early warnings of intrusion. Incident response procedures are also being reviewed and updated to provide the fastest remediation of identified problems. These actions are expected to be complete by November 2010.

A limited number of staff with justifiable business needs have been given special training and access to social networking sites. The agency will continue to restrict general access to these sites. If future needs arise that require a greater expansion to a larger number of staff, new network security tools would be needed to provide further layers of detection and protection from the new breed of attacks that target social networking sites.

There are currently several security measures in place that provide a high level of protection for our mobile technology. These include:

- Offline authentication is required immediately after boot-up;
- Application software encrypts the files that are most used by caseworkers; and
- Special software tracks lost or stolen devices and automatically wipes the hard drive when detected through an Internet connection.

While these measures offer a high level of protection, the agency is studying other protective measures, including:

- Hard disk encryption—With an expected completion date of August 2010;
- External storage devices—Under study; and
- Email encryption—Under study.

## 7.4.3 Improving Data Quality and Use

### Data and Reports

The availability of, and access to, information is vital to agency leadership, clients, stakeholders, media, the Legislature, oversight entities, and other interested parties. There is a constant need for timely and reliable data both to meet *ad hoc* requests and to support publication of required reports. A few examples of the many reports that are regularly issued include the CPS Disproportionality Report, Human Resources Management Plan required by the DFPS Rider 13 of the 2010-11 GAA, the Foster Care Capacity-Building Report, the APS Customer Satisfaction Survey Results Report, and others including state plans and required federal and state financial and programmatic reports.

In addition to all other reports, the agency issues the Annual Report and Data Book, which is an overview of programs, services, performance, accomplishments, and a comprehensive statistical resource of DFPS activities. The Annual Report and Data Book is posted on the agency's website and available to the public.

## 7.5 DFPS Initiatives

### 7.5.1 Investigations Improvement Project

The APS Mental Health (MH) and Mental Retardation (MR) investigations improvement project is a significant DFPS initiative to implement improvements in the MH and MR Investigations program mandated by the 81<sup>st</sup> Legislature, as well as other ongoing improvements:

- S.B. 643, 81<sup>st</sup> Legislature, Regular Session, 2009,
- Senate Concurrent Resolution (S.C.R.) 77 (which approves the changes called for in the 2009 Department of Justice Settlement), and
- S.B. 806, 81<sup>st</sup> Legislature, Regular Session, 2009.

S.B. 643 transferred the authority to investigate private Intermediate Care Facilities for Persons with Mental Retardation (ICFs-MR), licensed by the Department of Aging and Disability Services (DADS), from DADS to DFPS. This change will add a new type of facility investigation to the MH and MR Investigations program. The bill also requires DADS to work with DFPS to develop and maintain a database with specific information on investigations in HCS group homes and all ICFs-MR. S.B. 643 also requires APS to notify the HHSC Office of Inspector General about state supported living center (SSLC) cases in which a crime may have been committed. Lastly, APS must establish protocols of communication, coordination and sharing of responsibilities with the newly created Independent Ombudsman for SSLCs. Changes resulting from this bill will require DFPS to hire and train additional APS field staff and database staff, train existing employees, change rules and policy,

coordinate with DADS and providers, enhance information technology, and create new data reports.

S.C.R. 77 approved the settlement agreement between the State of Texas and the U.S. Department of Justice (DOJ). The agreement requires APS to meet certain criteria in conducting investigations in SSLCs. It requires the following changes: APS must complete SSLC investigations within 10 calendar days, all APS MH and MR program investigations must be reviewed and approved by the supervisor, and investigators must consider as evidence previous serious incidents involving both alleged victims and the alleged perpetrators. The settlement agreement requires implementation of these changes within 12 months of its filing date of June 26, 2009. All changes were completed by June 2010.

To achieve success in implementing these changes, APS was appropriated funds to hire new investigators and supervisors to create functional units that reduce the span of control for supervisors from six investigators to five.

The changes in the DOJ settlement will result in the need for DFPS to hire and train additional MH and MR field staff, acquire office space and additional equipment, train new and existing employees, change rules and policy, coordinate efforts with DADS, make information technology enhancements, and create and maintain new and revised data reports.

Effective September 1, 2010, S.B. 806 requires DFPS to report to the EMR any staff of SSLCs, state centers, and state hospitals who are found to have engaged in reportable conduct (e.g. physical abuse or neglect that caused or may have caused serious physical injury or death, or sexual abuse). DFPS is responsible for processing the referrals made to the EMR, and for preparing for EMR appeals. APS regional management staff will review the investigations to determine whether the findings meet the definition of reportable conduct, APS State Office will register the additional workers in the EMR, and DFPS Legal Services attorneys will prepare the cases for HHSC appeals hearings.

In addition to implementing legislative changes, the MH and MR investigations improvement project includes ongoing improvements resulting from the recent self-assessment workgroup. To increase APS' protection of HCS clients, APS will work to identify trends and patterns of abuse, neglect, and exploitation in HCS waiver programs that can then be reported to DADS. DFPS must use existing resources and attempt to produce longitudinal and cross-regional data. APS will coordinate with DADS in the development of the mechanisms to create and present the data.

Recent events have impressed upon APS the importance of continuing and expanding its efforts to improve quality in MH and MR investigations, so APS has included the objective of increasing oversight and trend analysis in APS MH and MR investigations. APS will perform research to attempt to identify abuse, neglect, and exploitation trends or patterns in groups of cases and increase oversight of open

investigations. For these measures to be successful in increasing client safety, additional resources may be needed for APS, as well as increased communication and collaboration with providers. APS will strive to create tools and mechanisms whereby gaps and errors can be recognized and addressed, develop new investigation and reporting functions for taking appropriate action when patterns exist, and improve case quality in APS MH and MR investigations.

DFPS received resources to implement some of the legislatively mandated changes. However, until APS begins to operate under the fully implemented changes, it is unclear if the resources will be enough to adequately meet the increased investigations, EMR cases, and coordination and data requirements associated with the vast changes in the program.

The measures outlined in the MH and MR investigations improvement project will improve overall quality in investigations, improve cross-agency coordination, and increase protection of vulnerable adults. Increased EMR referrals will make it less likely that confirmed perpetrators will have the chance to place vulnerable adults at risk in the future. Determining patterns and trends in abuse, neglect and exploitation cases can help identify ways to improve investigations and opportunities to inform providers of ways to prevent maltreatment. Ultimately, these program improvements will improve the quality of investigations and provide greater protection to vulnerable adults.

## Chapter 8

# Department of State Health Services External/Internal Assessment

### 8.1 Overview

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 \$2.9 billion and a workforce of approximately 12,500 employees, DSHS is the fourth largest of Texas' 178 state agencies. DSHS manages nearly 5,400 client services and administrative contracts and conducts business from 157 locations.

The agency's focus on public health and behavioral health provides DSHS with a broad range of responsibilities associated with improving 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 country, within Texas, and along the United States/Mexico border. Service system partners such as DSHS regional offices, DSHS hospitals, Local Mental Health Authorities, Federally Qualified Health Centers, local health departments, and contracted community service providers serve important roles in working collaboratively to address existing and future issues faced by the agency.

The material in this chapter is arranged as follows:

- Mission;
- External Assessment: Challenges and Opportunities, and Planned Actions;
- Internal Assessment;
- Cross-Agency Coordination and Planning Initiatives; and
- DSHS Initiatives.

Appendix F includes a description of the agency target populations and service descriptions.

## 8.2 Mission

The mission of DSHS is to improve health and well-being in Texas.

## 8.3 External Assessment: Challenges and Opportunities, and Planned Actions

Some of the more prominent external and internal challenges and opportunities that impact DSHS as the agency works toward addressing the strategic priority of improving health and well-being in Texas are described below:

- Addressing Public Health and Mental Health Needs;
- Preventing Chronic Disease, Infectious Disease, and Substance Abuse;
- Improving Response to Public Health Threats and Disasters;
- Increasing Emphasis on Health Care Quality;
- Public Health Data Capacity; and
- Maintaining Regulatory Structure and Capacity.

### 8.3.1 Addressing Public Health and Mental Health Needs

As the population of Texas grows, so does the demand for public health, and primary and behavioral health services. These increasing demands often impact 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.

Strategic Priority: Improve the health and well-being of Texans.

- Emphasize health promotion, primary care, disease prevention, and early intervention for improved long-term health outcomes.
- Improve access to services that address behavioral health needs.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with families, stakeholders, community organizations, providers, and others in the public to address service delivery issues and ensure customers receive timely, appropriate services.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Ensure the safety and well-being of Texans in state-operated and contracted residential facilities, as well as those provided services in their homes.

## **Discussion**

### ***Public Health***

The contribution of public health efforts to our society is measured in the dramatic improvements in well-being and life expectancy during the 20<sup>th</sup> century. Within that timeframe, 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 improvements in public health, rather than improvements in drugs, treatment, and medical care.

Immunizations, clean water, clean air, sanitation improvements, and food quality controls have dramatically improved the quality of life for most Americans.

Despite these public health improvements, significant health issues remain. Chronic diseases are the leading causes of death in the U.S. and Texas and will be discussed in Section 8.3.2, Preventing Chronic Disease, Infectious Disease, and Substance Abuse, later in this chapter. Another remaining health issue is infant mortality, which can be addressed through a number of interventions and population-based efforts. The Healthy People goal for infant mortality is a rate of 4.5 deaths among infants less than 12 months of age, for every 1,000 live births. In 2006, the infant mortality rate (IMR) in Texas was 6.2 (2,476 deaths out of 399,309 live births), with the highest rate among African Americans, at 12.3 (564 infant deaths out of 45,877 live births). The three main causes of infant mortality include: birth and genetic defects, prematurity (including low birth weight), and Sudden Infant Death Syndrome (SIDS). Reduction in the IMR is a top priority for the agency.

### ***Mental Illness***

Mental illness is a leading cause of disability in the U.S., Canada, and Western Europe. In general, 19 percent of the adult U.S. population have a mental disorder alone, during the course of one year; 3 percent have both mental and addictive disorders. In Texas, the 2009 estimated number of adults with serious and persistent mental illness was 467,226. Approximately 20 percent of children are estimated to have mental disorders with at least mild functional impairment. Federal regulations also define a sub-population of children and adolescents with more severe functional limitations, known as “serious emotional disturbance” (SED). Children and adolescents with SED comprise approximately 5 to 9 percent of children ages 9 to 17.<sup>1</sup>

DSHS-funded community mental health services (including NorthSTAR) served 150,075 adults in fiscal year (FY) 2009. The 2009 estimated number of children in Texas with severe emotional disturbance was 167,189. DSHS-funded community mental health services (including NorthSTAR) served 40,551 children in FY 2009.

DSHS operates and maintains state-owned facilities, which provide 24-hours-per-day, 7-days-per-week direct services to individuals requiring inpatient or residential services. Some of the state facilities have experienced the need for increased

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<sup>1</sup> <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

capacity, and some require additional maintenance due to the aging infrastructure. Additionally, state-operated psychiatric hospitals have experienced an increased use of resources by the forensic population. Forensic commitments are individuals committed to state mental health hospitals under the criminal code. These individuals have committed crimes and are not competent to stand trial or were found not guilty by reason of insanity. They are committed to state hospitals for competency restoration. The number of patients committed on forensic commitments increased from 16 percent admissions in 2001 to 36 percent in 2008. This results in a corresponding reduction of beds for civilly committed patients. Adjusting to the increasing forensic population has provided numerous challenges and has the potential to change the focus and direction of the state mental health hospital system.

A behavioral health service continuum is comprised of services ranging from prevention and early identification to residential treatment and in-patient 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 explore additional capacity for the prevention and appropriate management of substance abuse and mental illness, and look to innovative approaches and best practices as a means to lessen the effects of the disorders. These approaches may include service integration as well as other strategies intended to direct individuals to more appropriate care settings, thereby avoiding jail, hospitalization and other more expensive services.

## **Planned Actions**

### ***2010 Title V Five-Year Needs Assessment***

States seeking Title V (federal Maternal & Child Health Block Grant) funding are required to submit a comprehensive needs assessment every five years. All state maternal and child health priorities and activities are derived from the results of the Title V Five-Year Needs Assessment, which is intended to identify priority needs so as to plan activities associated with the following areas:

- Preventive and primary care services for pregnant women, mothers, and infants;
- Preventive and primary care services for children and adolescents; and
- Services for children with special health-care needs.

The last statewide assessment was completed in 2005 and submitted with the FY 2006 Title V Application. Development of the FY 2010 assessment is currently in progress under the direction of the Family & Community Health Services Division. This assessment will represent priority areas of focus for services to Texas children and families during the next five years.

- The Title V Five-Year Needs Assessment will be submitted to the Maternal and Child Health Bureau in the Health Resources and Services Administration on July 15, 2010 (2011-15).

### ***Enhance Community Mental Health Services***

During the 80<sup>th</sup> Legislative Session, DSHS requested and received \$82 million to implement a statewide redesign of mental health crisis services. This funding has allowed all communities across Texas to have access to:

- An American Association of Suicidology accredited crisis hotline, and
- A mobile crisis outreach team.

The 81<sup>st</sup> Legislature appropriated an additional \$55 million dollars for the 2010-11 biennium for community mental health crisis services. For FY 2010, this initiative was implemented through contract amendments with local mental health authorities (LMHAs) and NorthSTAR. These resources have enabled further enhancements to the crisis service delivery system, such as:

- 90-day post-crisis transitional services, and
- More intensive post-crisis mental health services for some individuals.

Milestones to ensure these enhancements are implemented include:

- Conducting ongoing communication activities with LMHAs and NorthSTAR (FY 2011-15), and
- Executing contracts (FY 2011).

### ***Capacity of State Mental Health Hospitals***

This initiative seeks to identify ways to address the state hospital capacity issue. State hospitals continue to operate at or above funded capacity, with several hospitals on diversion (triaging patients to hospitals with available beds) on most days. More than 500 patients have been in the hospital for more than a year because they require supports not available in the community. Forensic commitments are also increasing. DSHS has started a Continuity of Care Task Force, which includes state hospital staff, LMHA staff, law enforcement, advocates, and judicial representatives, and DSHS seeks to make recommendations to address the capacity issue.

Milestones include:

- Continuity of Care Task Force, holding meetings and public forums, and producing a final report by August 31, 2010.
- Identifying priorities and developing a plan for addressing issues during the next five fiscal years (2011-15).

## 8.3.2 Preventing Chronic Disease, Infectious Disease, and Substance Abuse

Chronic and infectious diseases and substance abuse impact thousands of Texans each year. Many of these conditions are exacerbated by health risk behaviors such as tobacco use, obesity, low physical activity, consumption of alcohol and other drugs, and poor nutrition.

Strategic Priority: Improve the health and well-being of Texans.

- Emphasize health promotion, primary care, disease prevention, and early intervention for improved long-term health outcomes.
- Improve access to services that address behavioral health needs.

### Discussion

#### *Chronic Disease*

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 the lives of more than 101,000 Texans annually and are responsible for seven of every ten deaths. See Chapter 3, Table 3.1 for more information.

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. CVD and stroke are the number one and number three causes of death in Texas. African Americans (non-Hispanic) had the highest rates of mortality from CVD in 2005, compared with Anglos (non-Hispanic) and Hispanics.

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 a smoking-related illness. More than one of every five Texas adults currently smokes tobacco. Approximately 24,000 adults die of a smoking-related illness annually in Texas. That is more than the combined deaths annually from Acquired Immunodeficiency Syndrome (AIDS), heroin, cocaine, alcohol, car accidents, fire, and homicide. 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.

Cancer, the second leading cause of death in Texas, represents more than 100 distinct diseases that are characterized by the uncontrolled growth and spread of

abnormal cells in the body. Significant contributors to the cancer rate include tobacco, poor nutrition, physical inactivity, obesity, and other behavioral 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. In 2010 it is estimated that more than 104,000 Texans will be newly diagnosed, and about 38,000 will die from cancer. African Americans living in Texas have the highest rate of cancer.

Diabetes can lead to disabling health conditions, including heart disease, stroke, kidney failure, leg and foot amputations, and blindness. One of the risk factors associated with the development of diabetes is obesity, which is increasing in prevalence. Estimates indicate that the total number of Texas diabetes cases 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. The 2006 mortality rates (per 100,000) for African Americans and Hispanics were more than double that of Anglos.

Obesity is a major driver of poor health in Texas, as it is a risk factor for chronic diseases such as type 2 diabetes, heart disease, stroke, arthritis, and certain types of cancer. Two out of three adult Texans are either overweight or obese, with rates higher among African Americans (73 percent) and Hispanics (75 percent) than among Anglos (62 percent). According to the Behavioral Risk Factor Surveillance System (BRFSS), conducted by the Centers for Disease Control and Prevention's (CDC's), persons of low socio-economic status are particularly affected—73 percent when annual income is less than \$25,000. Data from the University of Texas School of Public Health indicates that in 2004-05, thirty-nine percent of Texas children in 4<sup>th</sup>, 8<sup>th</sup>, and 11<sup>th</sup> grades were overweight or at risk for being overweight. The population of Texas is increasing at almost twice the rate of the national population, and the fastest growth is among populations with the highest rates of obesity. If current trends continue, it is projected that 20 million or 75 percent of adult Texans will be overweight or obese by the year 2040.

### ***Infectious Disease***

Bacteria, viruses, or other microorganisms cause infectious diseases. Information regarding Human Immunodeficiency Virus Infection/Acquired Immunodeficiency Syndrome (HIV/AIDS) and Tuberculosis (TB) is provided below.

From 2003 to 2007, the number of persons living with HIV increased by more than 30 percent. At the end of this period, there were more than 62,000 people living with HIV in Texas. These increases are primarily due to the life-extending effects of treatment. As the number of Texans with HIV grows, so do the costs of providing treatment medications. The importance of maintaining programs and access to medical care and adherence services continues as a high priority. It is also increasingly clear that access to mental health and substance abuse treatment

services and availability of medical transportation both play key roles in keeping persons with HIV in care and treatment.

In Texas, the 2008 rate of persons living with HIV/AIDS among African Americans (868.3 per 100,000 population) 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 above 1,000 per 100,000 population (i.e. over one percent of the population in question were infected). African-American men older than 35 years of age were the most affected subpopulation in each metropolitan area.

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 may also be produced when using certain methods to obtain specimens for testing, in a hospital or laboratory.

In 2009, there were 1,501 cases of active TB in Texas. Foreign-born persons account for a significant percentage of TB morbidity. The percentage of foreign-born cases with active TB disease has steadily increased over the past 10 years. Foreign-born persons represented 39 percent of TB cases reported in 1999, increasing to 53 percent in 2009. A higher number of TB cases in Mexican states that border Texas contributes to higher TB rates in the 14 contiguous Texas border counties. In 2009, Texas border counties had a TB rate of 10.3 cases per 100,000 residents, while non-border counties had a TB rate of 5.6 per 100,000. The total state rate was 6.0 per 100,000 residents.

### ***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. Additionally, substance abuse is often an underlying condition for many individuals involved with the criminal justice system. It also has a significant impact on an individual's physical health. According to the 2008 Texas BRFSS, approximately 48.5 percent of Texas adults reported that they had consumed alcohol in the past month, 14.7 percent reported past-month binge drinking, and 4.9 percent reported that they were heavy drinkers. (Note: For men, heavy drinking is typically defined as consuming an average of more than two drinks per day. For women, heavy drinking is typically defined as consuming an average of more than one drink per day.)

The percentage of heavy drinkers by race/ethnicity was 6.0 percent for Anglos, 4.1 percent for Hispanics, and 3.2 percent for African Americans. According to the 2007 National Drug Use and Health Survey, approximately 6.36 percent of Texans aged 18 or older reported being past-month users of any illicit drug, such as marijuana, cocaine, crack, hallucinogens, inhalants, and heroin. This percentage by

race/ethnicity was 7.7 percent for African Americans, 7.5 percent for Anglos, and 4.8 percent for Hispanics.

Among the youth population, the 2008 Texas School Survey of Substance Use found that 23.9 percent of Hispanic secondary students reported past-month binge drinking, compared to 20.7 percent of Anglo students and 11.7 percent of African-American students. The percentage of past-month illicit drug use was 13.2 percent of Hispanic students, 10.7 percent of African-American students, and 10.5 percent of Anglo students. Hispanic students in the border area reported higher rates in cocaine and Rohypnol consumption than their non-border peers.

## **Planned Actions**

### ***Obesity Prevention***

The 81<sup>st</sup> Legislature allocated funds to address the obesity issue in the state. DSHS allocated these funds to various communities across the state for projects that increase access to healthy foods and improve opportunities for safe, free physical activity. These strategies are consistent with evidence-based approaches defined by the Institute of Medicine report, “Local Government Action to Prevent Childhood Obesity,” and the CDC’s recommended community strategies for the prevention of obesity in the United States.

This initiative addresses four major areas, including:

- Developing a grant program for community-level obesity prevention initiatives using exceptional item funding;
- Determining the impact of stimulus funding and related riders in Article XII of the 2010-11 General Appropriations Act (GAA) (S.B. 1, 81<sup>st</sup> Legislature, Regular Session, 2009);
- Utilizing the University of Texas Medical Branch Stark Center’s diabetes model to establish four regional centers in Webb, Cameron, Nueces, and Galveston Counties, as required by the DSHS Rider 95 in the 2010-11 GAA; and
- Contracting with Texas Tech University and coordinating with the Chronic Kidney Disease Task Force to conduct a study to address kidney disease and its precursors, as required by the DSHS Rider 96 in the 2010-11 GAA.

Planned actions will include the following activities.

- Continuing to monitor community-based obesity prevention initiatives across Texas and to identify areas in which the evidence suggests that the approaches may be making an impact on childhood obesity rates (FY 2011).
- Identifying potential approaches that may be replicated by other communities across the state, if additional resources are available (FY 2011).

## **HIV/AIDS**

Studies have shown that one of the primary ways to reduce the number of new HIV cases is to intensify prevention work focused on those individuals at highest risk. This includes maintaining effective public health systems that provide contact tracing, partner services, and Sexually Transmitted Diseases (STDs) detection and treatment. To further reduce the spread of HIV, more HIV-infected persons need to receive effective treatment to reduce their viral load. These individuals can be identified when HIV testing opportunities are broadened. DSHS is involved in an initiative to expand the number of emergency departments and large primary care clinics associated with indigent care systems that adopt routine, opt-out HIV testing. Focus will be on high morbidity areas, such as Houston and Dallas, and will create routine, integrated, and sustainable HIV testing in these settings. This expansion is guided by the DSHS Rider 82 in the 2010-11 GAA, requiring DSHS to allocate not less than \$4,419,989 in FY 2010 and \$4,419,990 in FY 2011 from funds appropriated in Strategy A.2.2 to increase HIV testing as described above.

- A Request for Proposal (RFP) has been issued, and interlocal contracts for testing have been awarded to Hospital Districts. Continued monitoring of services delivered and approaches utilized to impact access to HIV services will occur (FY 2011).
- Additional contracts for testing based on the RFP have been awarded and will be monitored and assessed to identify areas where evidence demonstrates improved access to testing services (FY 2011).
- Data collection and evaluation plans have been established and will be monitored regularly to identify approaches that demonstrate positive outcomes (FY 2011).

## **Medicaid Substance Abuse Expansion**

DSHS operates both prevention and treatment programs to address substance abuse. The 2010-11 GAA directs HHSC to implement a comprehensive Medicaid substance abuse benefit for adults. The proposed benefit expansion will extend to youth as well. HHSC and DSHS staff have been working collaboratively on this project, designing the proposed benefits, processes, communications, and other critical activities associated with implementation. HHSC is currently in the process of submitting a Medicaid State Plan Amendment to the Centers for Medicaid & Medicare Services (CMS) for approval to operationalize these benefits. The final array of services to be provided is dependent on CMS approval. The proposed array of services includes detoxification, residential treatment, outpatient treatment, and medication-assisted treatment.

- The proposed implementation date is September 1, 2010.
- The cost-effectiveness of this new benefit will be analyzed by the Legislative Budget Board (LBB) in February 2013. Continuation of the benefits is contingent on the LBB cost-effectiveness analysis.

### **8.3.3 Improving Response to Public Health Threats and Disasters**

Texas faces many different emergency situations, ranging from hurricanes, floods, and tornados to infectious disease outbreaks. In a state the size of Texas, with very large and small communities, planning and response activities require close coordination with state and local jurisdictions, health departments and responders, and the Texas Division of Emergency Management (TDEM). An effective health and medical response to public health emergencies requires fully trained response teams, tools and procedures, and clear roles and responsibilities among state agencies and local response partners. 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.

#### Strategic Priority: Improve the health and well-being of Texans.

- Emphasize health promotion, primary care, disease prevention, and early intervention for improved long-term health outcomes.
- Improve access to services that address behavioral health needs.

#### Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with families, stakeholders, community organizations, providers, and others in the public to address service delivery issues and ensure customers receive timely, appropriate services.

### **Discussion**

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 chemical, biological, radiological, and nuclear (CBRN) events.

### **Planned Actions**

#### ***All Hazards Planning and Response***

The All Hazards Planning and Response initiative prepares for: infectious disease outbreaks such as influenza; natural disasters such as hurricanes, fires and floods; and CBRN events, as described above. This initiative carries out the following activities for each type of disaster event:

- Development of a staffing strategy;
- Roster response teams based on skills set, or response teams;
- Revision and development of procedures and plans aligned with the type of disaster event; and

- Development of training plans and hosting of training sessions.

Additionally, new procedures have been developed using the All Hazards approach.

- An All Hazards training plan has been developed and training for response team members has begun, and will continue periodically (2011-15).
- DSHS will continue to stand ready to prepare for and respond to public health emergency events (2011-15).

### ***Emergency Preparedness Training***

Adequate planning, training, and exercises are all important factors in a successful emergency preparedness program, which then leads to a successful health and medical response. DSHS is currently developing an emergency preparedness training program dedicated to the enhancement of all-hazards response capabilities across the state with our health and medical partners. This developing program is establishing goals and objectives that complement national standards and will fortify our current health and medical response capabilities. The program goals include:

- A training certification program that is National Incident Management System (NIMS) compliant,
- Training guidance and technical assistance to our health and medical partners statewide,
- Development of training specific to the needs of the DSHS Multi-Agency Coordination Center (MACC) and the State Operations Center (SOC), and
- Development of an extensive array of relevant e-learning modules.

Planned actions include:

- Continuing to stand ready to prepare for and respond to public health emergency events (2011-15).

### ***Continuity of Operations***

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. The activities below have been conducted in association with the Continuity of Operations (COOP) functions:

- DSHS Business Continuity Policy approved;
- HHS Business Continuity Program Workgroup established;
- Detailed COOP Plan reviewed and approved by DSHS Commissioner;
- DSHS COOP Plan submitted to State Office of Risk Management (SORM);
- DSHS COOP Exercise Program developed and implemented, which included a process to ensure that after action reports and corrective action plans (CAP) are completed after each exercise and that COOP plans are updated in accordance with the CAPs;

- Business Impact Analysis (BIA) updated to provide a decision matrix for implementing operational changes based on impact of event on staffing;
- Pan Flu COOP operational guidelines developed for activation, implementation, and reconstitution;
- A process and method for communicating status and operational changes to employees and stakeholders developed;
- Operational guidelines adapted to limit worksite virus transmission and implement social distancing practices—for example: enhanced hygiene practices, personal protective equipment, canceling events, tele-work and staggered shifts;
- A vendor contracted to provide services for seven state agencies, including DSHS, to evaluate COOP planning for those agencies, develop operational guidelines for three critical components (human resources policy, communications, and social distancing measures with a focus on tele-work) and to train and exercise agency staff to those areas; and
- DSHS will continue to stand ready to prepare for and respond to public health emergency events, including implementation of COOP plans, should the need arise (2011-15).

### **8.3.4 Increasing Emphasis on Health-Care Quality**

DSHS has been increasingly involved in state efforts to improve the quality and safety of health care in Texas.

Strategic Priority: Improve the health and well-being of Texans.

- Provide an outcome-based, quality-oriented system of care.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Ensure the safety and well-being of Texans in state-operated and contracted residential facilities, as well as those provided services in their homes.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with families, stakeholders, community organizations, providers, and others in the public to address service delivery issues and ensure customers receive timely, appropriate services.

### **Discussion**

Chapter 98 of the Texas Health and Safety Code requires the agency to compile and make available to the public a summary, by health-care facility, of health-care associated infections reported by the facilities. The 80<sup>th</sup> and 81<sup>st</sup> Texas Legislatures took steps toward improving patient safety. Examples include S.B. 288, 80<sup>th</sup>

Legislature, Regular Session, 2007 and S.B. 203, 81<sup>st</sup> Legislature, Regular Session, 2009. Each of these initiatives share similar objectives: to assist consumers in making informed health-care decisions and minimizing the administrative burden on facilities in reporting data.

## **Planned Actions**

### ***S.B. 288 Healthcare Associated Infections and S.B. 203 Preventable Adverse Events Reporting***

Approximately 130,000 to 160,000 infections associated with health care are expected to occur annually in Texas at an estimated cost as high as \$2 billion. S.B. 288 addressed this issue by requiring DSHS to establish a Healthcare Associated Infections (HAI) reporting system. In addition, this legislation charged 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.

S.B. 203 passed in 2009, requiring DSHS to create a system for reporting preventable adverse events (PAE), including such “never events” as amputation of the wrong limb. The HAI Advisory Panel was expanded from 16 to 18 members and was renamed the Advisory Panel on Health Care Associated Infections and Preventable Adverse Events.

- Development of rules for PAE reporting (FY 2011).
- Development of HAI database, data validation tools, and website by December 31, 2010 (FY 2011).
- Facilities begin reporting HAI in early 2011 (FY 2011).

### ***Potentially Preventable Hospitalizations***

Adult Texans experienced more than one million “potentially preventable hospitalizations” at a cost of more than \$30 billion from 2005 to 2008, approximately \$1,800 for every adult Texan. To address this impact, DSHS provides information to state, regional, county and community stakeholders on the impact of “potentially preventable hospitalizations” in Texas. This information emphasizes the financial impact of these hospitalizations and best practice interventions to avoid the hospitalization. The purpose of the information is to assist in improving health care and reducing health-care costs for Texas residents; it is not used as an evaluation of hospitals or other health-care providers, as there are multiple factors that can influence these rates.

The following ten conditions are classified as “potentially preventable hospitalizations” because hospitalization would potentially have not occurred if the individual had had access to, and cooperated with, outpatient health care:

- bacterial pneumonia,
- dehydration,
- urinary tract infection,
- angina (without procedures),
- congestive heart failure,
- hypertension,
- asthma,
- chronic obstructive pulmonary disease,
- diabetes short-term complications,
- and diabetes long-term complications.

Data come from hospitals in Texas that are required to submit inpatient hospital discharge data to the DSHS Center for Health Statistics. For more information on “potentially preventable hospitalizations” in Texas please go to: <http://www.dshs.state.tx.us/ph>.

- Continued partnerships with local communities to conduct assessments designed to identify risk areas and assist with development of plans to address issues and improve outcomes (2011-15).
- Identify resources that would enable the expansion of efforts across the state and decrease preventable hospitalization events by 15 percent (2012-13).

### **8.3.5 Improving Public Health Data Capacity**

There is an urgent need to create health information systems that will support public health activities and improve health-care quality and control costs. Technological advances will be required to address this issue as well as changes made to existing statutes to enable the intra-agency sharing of data.

Strategic Priority: Improve the health and well-being of Texans.

- Emphasize health promotion, primary care, disease prevention, and early intervention for improved long-term health outcomes.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Improve our ability to detect potential risk to vulnerable children and adults in the community.

## **Discussion**

At both state and national levels, there is increasing discussion among insurers, provider associations, and governments about how to build secure health information exchanges to improve quality and control costs. One of the components in Texas includes DSHS public health data, including ImmTrac, Vital Statistics, and the Cancer, Trauma and Birth Defects Registries. Aside from the technological advances required to address this issue, changes may need to be made to existing statutes to enable the intra-agency sharing of data.

## **Planned Actions**

### ***Health Registries Improvement Initiative***

The goal of the project is to improve the timeliness, completeness, and validity of health information collected through registries and disease surveillance systems. The assessment should address upgrading sub-standard technology to web-based systems, integration of common functions such as receipt and management of electronic lab reporting across registries, removing duplicative reporting from common sources of data (e.g. hospitals), and data linkages which would improve efficiencies in data collection. Registries that will be included are those devoted to birth defects, cancer, trauma, lead poisoning, immunizations, and infectious diseases.

- Conduct a technological assessment of select health registries in the Environmental Epidemiology and Disease Registries Section and in other disease surveillance program areas (FY 2010).
- Implement recommendations for improvements in technology and data collection based on this assessment (FY 2012).
- Develop “blueprint” recommendations for maximal and beneficial integration of health registries (FY 2011).

### ***Clinical Management for Behavioral Health Services***

Clinical Management for Behavioral Health Services (CMBHS) is an electronic health record designed to replace the legacy information technology systems for mental health and substance abuse. The first production release of CMBHS was successfully deployed to Austin-area substance abuse providers in December 2009. The application will be deployed to substance abuse providers across the remainder of the state on a region-by-region basis. A second production release is currently under development and will include substance abuse prevention and intervention data as well as more advanced medication data. The second production release is scheduled for deployment in the 4<sup>th</sup> quarter of FY 2010.

A data exchange approach is being developed to allow mental health providers to automatically transmit information into CMBHS from their local electronic health records. A data standards workgroup that includes DSHS staff and mental health

provider staff is currently working to finalize the data elements and formats for the data exchange.

- Finalize second production release of the application for deployment to various behavioral health providers (FY 2010).
- Incorporate policy, programmatic, and resource issues garnered from this project into the broader HHSC state planning efforts associated with health information technology, health information exchange, and electronic medical records (FY 2010).

### **8.3.6 Maintaining Regulatory Structure and Capacity**

The state must maintain an adequate regulatory framework to protect the health of Texans.

Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.

- Improve our ability to detect potential risk to vulnerable children and adults in the community.
- Ensure that licensing and regulatory authorities hold public and private sector providers accountable for the health and safety of clients.

Strategic Priority: Strengthen and support the health and human services workforce.

- Recruit high-quality staff.

#### **Discussion**

Activities of the Regulatory Division protect consumer health and safety. DSHS licenses health facilities and certain health professionals. The agency also regulates manufacturers and processors of consumer products such as prescription drugs, medical devices and food and the use of radiation in industry and medical offices.

The number of licenses issued in the past five years has increased dramatically and continued growth is anticipated as the state grows. Additionally, programs added by both federal and state government increase the need for additional licensure, investigatory and enforcement activities. To keep pace with population growth and the number of licenses, DSHS must recruit trained professionals capable of performing the technical inspections and reviews necessary to protect the health of the state.

The regulation of the food supply is a complex matrix of local, state and federal laws. This complexity is exacerbated by the breadth of actions covered, which include both the development of rules and regulations for the industry and actions associated with enforcing them. These regulatory activities include: requisite

complaint and compliance investigations, enforcement actions, outbreak investigations, the public health response to those outbreaks, and related considerations as diverse as laboratory testing capacity, international commerce and transportation. More than 200 known diseases are transmitted through food including salmonellosis, listeriosis, Escherichia coli O157:H7 and campylobacteriosis, and it is estimated that food borne disease causes approximately 6 million illnesses, 26,000 hospitalizations and 400 deaths in Texas each year. This was recently emphasized by the large outbreaks of salmonellosis involving consumption of peanuts, pistachios, alfalfa sprouts, tomatoes, and peppers.

## **Planned Actions**

### ***Additional Funding for Regulatory Services***

In the 81<sup>st</sup> Legislative Session, DSHS requested and received funding to help meet the increased demand for licenses, compliance, enforcement activities, and new federal programs, such as the safety plan now required of food processors and increased monitoring of radioactive materials. DSHS also received funds to offer more competitive wages to professionals in critical regulatory positions.

- Continue to monitor the existing and forecasted growth in demand for regulatory services and assess the concurrent resource issues associated with agency and workforce capacity, recruitment and retention (2011-15).

### ***Food Safety***

DSHS has primary responsibility to license and inspect food manufacturers, distributors (including distributors of imported foods), and retailers in Texas. However, not all segments of the food supply chain are adequately regulated and loopholes exist in statute that specifically exempt or don't address significant portions of the "farm to fork" supply chain. Of the portions of the food supply chain that are regulated, there are approximately 24,000 manufacturing and distribution licensees and 96,000 retail foods licensees; 85,000 of those are licensed and inspected by local health departments. DSHS recognizes that there may be manufacturing, distributing and/or retail facilities that are not licensed either willfully or through lack of knowledge of the law. DSHS must work with partners at the federal, state and local level to continue to strengthen the food safety system.

- Continue to work with local, state, and federal agencies and academic institutions to identify issues associated with risk characterizations of inspected establishments. Utilize this information to craft best practices for inspection techniques (FY 2011).
- Implement activities funded through a grant from the Food and Drug Administration (FDA) to establish rapid response teams for food borne illness outbreaks, and to adopt national manufactured foods voluntary standards designed to reduce the occurrence of food-borne illness outbreaks (FY 2011).

- Continue to monitor federal efforts by the FDA and Texas Department of Agriculture (TDA), and gather information on new produce food safety rules to be promulgated by FDA (FY 2011).
- Food safety improvement will be a priority initiative for the 82<sup>nd</sup> Legislature. Closing the exemption for produce is an important step towards improving food safety in Texas and the nation. DSHS will continue to discuss additional testing with industry to seek a solution that protects public health by focusing on those sectors of the industry that pose the greatest risk (2011-13).

## 8.4 Internal Assessment

### 8.4.1 Maintaining and Developing the Workforce

Surging population growth, shifting demographic trends, and an aging workforce create challenges in maintaining and developing an efficient, effective, and well-trained workforce, which is vital to protecting and improving the health and well-being of Texans. Any other potential significant changes in the labor market could jeopardize the acquisition, development, deployment, and retention of a current competent workforce. DSHS must continue to collaborate with institutions of higher education to attract candidates with specialized education and training in public health. Continued efforts must support critical training needs in technical areas to enhance and sustain a skilled staff fully engaged in the operations of the organization. The ability to survive competition in other sectors of the labor market will rest upon comprehensive strategic initiatives and optimizing workforce management resulting in the successful performance of our mission.

### 8.4.2 Addressing Infrastructure Needs

DSHS Information Technology (IT) is in a state of transition from a largely reactive, silo-based, hardware-driven environment to a proactive, service delivery focused, and data driven infrastructure. The DSHS statewide IT network supports the delivery of public health services to more than 141 health service offices, 13 hospitals, and 5 Austin Metropolitan Offices for the 13,000 DSHS employees. Over the last four years, significant investment has been made in the network infrastructure to ensure network reliability, performance, security, and connectivity redundancy for the agency. Cost containment strategies have been implemented to drive out old technology utilizing seat management and leasing strategies in order to provide current infrastructure at the desktop. Data security has been enhanced through the deployment of infrastructure for email filtering (for the prevention of external attacks such as virus, spyware, malware, and hackers), intrusion detection, software patch management, encryption, and laptop computer tracking. While much has been accomplished on the hardware infrastructure initiatives, the remaining

challenge is significant. The statewide contract to outsource data center services is at least two years behind in consolidating servers. For DSHS, the result is that the agency is still faced with more than 500 servers over five years old. There is no firm replacement date at this time. This impacts every program and administrative area within DSHS.

The strategic focus is shifting to availability, quality, accessibility, security, and sharing of data. The systems currently being re-engineered or remediated all include requirements for web-enabling, standards-based architecture, federal and state rules compliance, and interoperability for data sharing. Examples include the Cancer, Trauma, and Birth Defects Registries; Healthcare Associated Infections; New Food Rules for the Women, Infants, and Children (WIC) program; Pharmacy and Emergency Preparedness Asset Management Systems; Automated Medication Administration Records System; and Clinical Management for Behavioral Health Services. Strategic initiatives will include evaluations of business intelligence software, e-discovery software, mobile applications strategies, and the use of field data collection and reporting applications utilizing smart phones.

The focus on data is supported by the Texas Statewide Plan for Health Information Technology (HIT), which is mandated by the Health Information Technology for Economic and Clinical Health Act (HITECH) 2009. This mandates broad adoption of the electronic health records and electronic medical record. Heightened requirements for interoperability, exchange, data protection, and security will result in shorter technology refresh cycles as the health-care industry evolves in response to recent reform. The DSHS technology infrastructure once perceived as a helpful tool for public health practice in Texas is now critical to achieving public health performance measures.

### **8.4.3 Improving Data Quality and Use**

Public health data are central to many health policy decisions. The collection, analysis, dissemination, and reporting of health data are scattered throughout DSHS and the HHS Enterprise. The DSHS Center for Health Statistics (CHS) is central to most of the data flows within DSHS. By linking clinical and administrative datasets together, it will be possible to advance knowledge about the comparative effectiveness of certain interventions as well as about the quality and efficiency of the health-care system as a whole. At present, there are statutory provisions prohibiting the linking of hospital discharge data with any other administrative or clinical datasets. This creates a challenge to devise meaningful quality or patient safety metrics. Vital Statistics and other data are prime for fraud, and therefore, data collection and sharing require standards that protect patient privacy, data confidentiality, and system security. CHS performs relatively sophisticated data-collection and has the expertise to compile large datasets and to contribute to the policy debate and involvement in pilots, projects or studies to improve the health and well-being of Texans. To improve the use of data, CHS could provide induction training about health statistics – how they are gathered, how to interpret them, and

how to use them in decision-making. CHS could establish and actively nurture relationships within academia so that they are ready to respond rapidly to future funding opportunities. Insufficient functional and analytical resources limit future movement to improve data quality and use.

## **8.5 Cross-Agency Coordination and Planning Initiatives**

### **8.5.1 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. Examples of certain initiatives DSHS is involved in are noted below.

#### **Emergency Preparedness and Response**

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 delegated authority for statewide emergency planning and coordination to Texas Division of Emergency Management (TDEM), which is part of the Texas Department of Public Safety.

Texas Government Code Chapter 421 and Section 418.042 require TDEM to 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. DSHS holds primary responsibility for 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.

## **Integration of Primary and Behavioral Health**

DSHS continues to strengthen the ability of the agency to holistically address the needs of service recipients impacted by both physical and behavioral health issues. House Bill 2196, 81<sup>st</sup> Legislature, Regular Session, 2009, established a workgroup charged to study and make recommendations on the integration of health and behavioral health services in Texas. DSHS serves as a member of the workgroup, which is managed by HHSC and comprised of individuals representing various constituencies at the state and local level. Through this effort, recommendations will be made to the Legislature regarding best practices in the areas of policy, training, and service delivery to promote integration within the state.

## **Mental Health Transformation**

In 2005, Texas received a five-year grant award from the Substance Abuse and Mental Health Services Administration. This initiative, the Mental Health Transformation State Incentive Grant, provided over \$13 million to the state to implement activities associated with reforming the mental health system. A multi-agency team, the Transformation Work Group (TWG), comprised of state agencies, elected officials and consumer representatives, was formed to provide oversight and guidance to DSHS to ensure the goals and objectives of the federal award were accomplished. The TWG plans to continue to meet and collaborate after the grant period ends, and it plans for sustaining some of the efforts funded through the grant have been initiated. One of the transformation efforts that has been sustained through additional funding from the Legislature is the Behavioral Health Services for Veterans and Their Families project that is mentioned further in this chapter, in Section 8.6.2, Community Health Services Initiatives.

## **8.6 DSHS Initiatives**

### **8.6.1. Preparedness and Prevention Services Initiatives**

#### **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 immunization 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 is currently implementing Article 12 of S.B. 11, 80<sup>th</sup> Legislature, Regular Session, 2007, and S.B. 347, 81<sup>st</sup> Legislature, Regular Session, 2009, to improve ImmTrac, the statewide immunization registry. ImmTrac continues to improve, and DSHS staff is working with stakeholders to identify and prioritize improvements. DSHS immunization activities also include participating in emergency preparedness and response, as vaccination of responders and persons affected by an event can be a key component of a successful response.

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 2008 indicate Texas' vaccine coverage level to be 77.8 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 2008 was 76.1 percent.

The latest data show low completion rates of 83.0 percent for children receiving the fourth dose of DTaP vaccine. In 2008, an education/awareness campaign was conducted to raise the awareness of providers who administered vaccines. The focus of the campaign was the timely administration of the fourth dose of the DTaP vaccine. In 2009, a second campaign was launched targeting women of childbearing age, 18 to 36 years of age who had children 0 to 36 months of age. The focus of the campaign was for each mother to get her children on schedule and stay on schedule. If both providers and parents worked together to ensure all children adhere to the ACIP Recommended Immunization Schedule at the time of birth and stay on schedule until the child has completed all the recommended vaccines, the immunization levels in Texas would be at 90 percent or better.

### **Tuberculosis Prevention and Control**

Just under \$7 million of state funds was appropriated to DSHS for the 2010-11 biennium for TB prevention and control through contracts with local health departments in areas of high TB morbidity. This initiative implements and tracks the following program activities supported by these funds.

- Additional funds were allocated to local health departments (LHDs) using the TB funding formula and health service regions (HSRs) received additional funds for local prevention and control activities.
- Additional funds have been allocated to the ongoing African-American TB Elimination Projects in Dallas and Houston to hire TB project coordinators.
- The Houston Department of Health and Human Services (HDHSS) was provided additional funds to support the TB Recovery Center (Langston House).
- DSHS TB program staff are collaborating with the HIV/STD program to consider an integrated system and to develop a cross-program proposal for the CDC on use of federal funds to support the needed systems. A DBITS

contractor has been hired to assess the data system needs of the programs and to identify commercially or publicly available software systems that may be appropriate for Texas.

- HSRs 1, 6/5S, and 7 have received small allocations of funds to support patient-centered interventions. These regions are using the funds to contract with outreach workers for directly-observed therapy.
- The Dallas County Health and Human Services Department received a small allocation to support a part-time contract outreach worker to work with clients who do not adhere to treatment.
- HSRs 9/10 and 11 received allocations of funds to identify children who are contacts to TB cases and obtain needed clinical evaluation of these children and treatment if needed.

### **Texas State Plan on Alzheimer’s Disease**

Health and Safety Code, Subtitle E, Chapter 101 established the Texas Council on Alzheimer's Disease and Related Disorders to serve as the state's advocate for persons with Alzheimer's disease and those who care for them. The Council, in March 2009, initiated activities associated with the development of the 2010-2015 Texas State Plan on Alzheimer’s disease. The draft plan was released for public comment in April 2010. The plan provides a comprehensive approach for addressing Alzheimer’s disease in Texas, including five specific goals, which consist of targeted actions that can be taken to address various aspects of the disease. The plan may be used to guide and coordinate state and local efforts to reduce the burden of this disease on Texans, and those who care for them.

## **8.6.2 Community Health Services Initiatives**

### **Behavioral Health Services for Veterans and Their Families**

As a result of interest expressed by the Governor’s Office and the Legislature, approximately \$5 million is available to implement the recommendations for behavioral health supports and services for veterans and their families as outlined in the Texas report titled “Behavioral Health Services for Returning Veterans and Their Families: Services, Gaps and Recommendations” ([www.mhtransformation.org](http://www.mhtransformation.org)). With these funds, DSHS is funding community-based projects through local mental health authorities (including the North Texas Behavioral Health Authority for NorthSTAR) to ensure that:

- Priority needs and gaps in behavioral health supports and services for veterans and their families are addressed statewide, and
- Constructive community partnerships for behavioral health supports and services for veterans and their families are established statewide.

### ***Tobacco Prevention and Cessation***

The 80<sup>th</sup> Legislature directed DSHS to fund evidence-based tobacco prevention and control activities at city and county health departments and/or independent school districts across the state. In February 2008, six community coalition contracts were awarded to develop a comprehensive program to meet DSHS tobacco program strategic plan goals. The goals of these coalitions are to provide evidence-based environmental tobacco prevention and control activities that:

- Prevent tobacco use among young people.
- Promote compliance and support adequate enforcement of federal, state, and local tobacco laws.
- Increase cessation among young people and adults.
- Eliminate exposure to secondhand smoke.
- Reduce tobacco use among populations with the highest burden of tobacco-related health disparities.
- Develop and maintain statewide capacity for comprehensive tobacco prevention and control.

These local tobacco coalitions developed a strategic plan for comprehensive activities in the community, and also developed an evaluation plan for assessing the effectiveness of the evidence-based tobacco prevention and cessation strategies that were implemented.

DSHS has funded a telephone Quitline since 2000, providing telephone counseling to tobacco users, tobacco education, and limited nicotine replacement therapy to Texas residents. The Quitline is currently using a five-session intervention that assists callers in assessing their nicotine dependence, setting a quit date, and providing longer-term support if necessary. Nicotine replacement therapy is available in the target communities and through a physician fax referral program that is available statewide.

Cessation efforts by the Tobacco Prevention and Control Coalitions educate the public and encourage health-care providers to take a more active role in promoting patient cessation. DSHS is also focusing on health insurance providers to educate them about clinical cessation counseling and pharmacotherapy.

In late 2008, Medicaid began exempting smoking cessation drugs from the Medicaid three-prescription limit. Previously, cessation medications had been subject to the three-prescription limit, which meant that Medicaid patients had to pay for cessation medications that were above the three Medicaid-funded prescriptions. This exemption will supply Medicaid providers with a new tool to help patients in their effort to quit smoking.

State level partnerships between the DSHS tobacco program and the Texas Medical Association's Physician Oncology Education Program, Nurses Oncology Education Program, the American Cancer Society, and the DSHS Women, Infants, and

Children program have been developed and maintained to ensure program success. These partnerships provide additional support to promote use of the Quitline by health-care clinicians, providers and insurers.

### **8.6.3 Hospital Facilities and Services Initiatives**

#### **Peer Support**

The department has initiated efforts to expand the use of trained paraprofessionals in a variety of health-care settings, including the incorporation of a peer support program in certain state hospitals. These individuals assist service recipients in identifying and achieving their goals relating to recovery and independence. Peer specialists provide support and guidance to hospital administrators, clinicians, patients and their families on various aspects of the treatment milieu. Through the provision of group facilitation, one-on-one interaction, and crisis intervention, peer specialists offer hope, empowerment, and linkage to services. Additionally, they provide public education to the community regarding mental illness, recovery, strength-based approaches to service delivery, consumer-involvement, stigma reduction, and peer support. The efforts of the peer specialists have resulted in an increased focus on recovery and consumer-oriented service approaches, and have impacted the incidents of restraint and seclusion.

#### **Facilities Construction/Renovation**

The Legislature approved three hospital construction/renovation projects for DSHS in the 80<sup>th</sup> Legislative Session.

##### ***Texas Center for Infectious Disease***

The plan for the new facility at the Texas Center for Infectious Disease (TCID) calls for the construction of a new 75-bed hospital building for inpatient care and treatment. This project includes improvements to TCID Women's Health Laboratory and TCID clinical support program areas, which will include a BSL-3 Isolation laboratory and updated radiology suite with new digitized imagery equipment, with minor renovations for pharmacy, medical records, financial management, physician offices, and information services. The project will be completed in August 2010.

##### ***Rio Grande State Center Outpatient Clinic***

The renovation/construction at the Rio Grande State Center (RGSC) facility includes building a new outpatient clinic, surrounding two existing buildings. The buildings will be renovated to provide patient support and program areas for the RGSC outpatient clinic along with 14,000 square of new construction. DSHS funds have also been allocated to demolish the abandoned wings of an additional building. This project will be completed in August 2010.

### ***Hidalgo County Primary Care and Substance Abuse Facility***

A new 11,000 square foot primary care and substance abuse facility is being built in Edinburg, which is in Hidalgo County. Land was transferred from Hidalgo County to the state for the purposes of building this facility, which will provide services to the Hidalgo County adolescent population. This project is slated to be finished in April 2011.

### **New Private Hospital Development Project (Montgomery County)**

Through the DSHS Rider 97 in the 2010-11 GAA, the 81<sup>st</sup> Legislature appropriated \$7.5 million in state funds for DSHS to allocate in FY 2011 to provide mental health services during the period from March 1, 2011, to August 31, 2011 at a facility newly constructed by a county for the purposes of providing contracted mental health services. Funds will be used to augment and enhance the array of services offered within the mental health services programs of DSHS, including the state hospital system. Montgomery County meets all of the criteria set forth in Rider 97 and has demonstrated an interest in working with DSHS to develop a plan for the operation of a facility that ensures that the mental health services to be provided will be comparable in quality and cost to services provided in other mental health services programs of the department.

## **8.6.4 Consumer Protection Services Initiatives**

### **Foodborne Illness Rapid Response Team Development**

As a result of several nation-wide food borne illness outbreaks over the last few years, FDA made the decision to invest in state regulatory program infrastructure, through grant awards, to build rapid response teams to identify the source and mitigate the consequences of outbreaks. Texas was awarded one of nine national grants in September 2009. DSHS and the Office of the Texas State Chemist, Feed and Fertilizer Program, are the grantee agencies. It is expected that over a three year period, Texas will develop these rapid response teams and build infrastructure for the foods regulatory programs.

### **Stroke Designation**

The Legislature passed S.B. 330, 79<sup>th</sup> Legislature, Regular Session, 2005, to develop a statewide stroke emergency transport plan and stroke facility criteria. The legislation focused on building a system where stroke victims are quickly identified, transported, and treated in appropriate stroke treatment facilities. The Governor's EMS & Trauma Advisory Council (GETAC) appointed a stroke committee to assist in the development of a statewide stroke emergency transport plan and stroke facility criteria. A wide variety of stroke and emergency health-care providers participated in the development of recommendations, including those who specialize in neurology, neuroradiology, neurosurgery, emergency medicine, and neuroscience nursing; and those emergency medical services (EMS) personnel who specialize in out-of-hospital care.

Rules regarding stroke designation went into effect August 30, 2009, and the first primary stroke center designation occurred on November 12, 2009. As of April 2010, there were 35 stroke centers designated in Texas.

# Chapter 9

## Goals, Objectives, and Strategies

The following presentation of goals, objectives, and strategies, by agency, reflects the structure proposed to 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.

### 9.1 Health and Human Services Commission

#### 9.1.1 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 2011, 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 2011, 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.

## 9.1.2 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 2011, 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. Non-Disabled Children.** 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.

**Objective 2-2. Other Medicaid Services.** By 2011, 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. Medical Transportation.** Support and reimburse for non-emergency transportation assistance to individuals receiving medical assistance.

**Strategy 2-2-4. Upper Payment Limit.** Provide supplemental Medicaid reimbursement to children hospitals for inpatient and outpatient services.

**Objective 2-3. Special Services for Children.** By 2011, HHSC will address the specific health and dental needs of Medicaid-eligible children in Texas before associated problems become chronic and irreversible.

**Strategy 2-3-1. Health Steps (EPSDT) Dental.** Provide dental care in accordance with all federal mandates.

**Objective 2-4. Medicaid Support.** By 2011, 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.

### 9.1.3 Goal 3: CHIP Services

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

**Objective 3-1. CHIP Services.** By 2011, HHSC will ensure health insurance coverage for eligible children in Texas.

**Strategy 3-1-1. CHIP.** Provide health care to eligible 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 eligible 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.

## 9.1.4 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 2011, 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 eligible 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.

**Objective 4-2. Other Support Services.** By 2011, 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.

## 9.1.5 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. Regional Program Support.**

## 9.1.6 Goal 6: Information Technology Projects

**Objective 6-1. Information Technology Projects.**

**Strategy 6-1-1. TIERS.**

## 9.1.7 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.

## 9.2 Department of Aging and Disability Services

### 9.2.1 Goal 1: Long-Term Services and Supports

*To enable Texans, who are aging or living with disabilities, to experience dignified, independent, and productive lives in safe living environments through a continuum of services and supports ranging from in-home and community-based services to institutional services*

**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 individual 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 aged 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 aging individuals, individuals 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 eligibles who 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 that will enable aging individuals, individuals 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.

**Strategy 1-3-3. -- Community Living Assistance and Support Services – Waivers.** Provide home and community-based services to individuals who have a "related condition" diagnosis qualifying them for placement in an Intermediate Care Facility. A related condition is a disability other than an intellectual or developmental disability which originates before age 22 and which substantially limits life activity. Such disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and other diagnoses, are said to be "related to" an intellectual or developmental disability in their effect upon the individual's functioning.

**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 individuals 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.

**Objective 1-4. Community Services and Supports—Non-Medicaid.** Provide non-Medicaid services and supports in homes and community settings to enable aging individuals, individuals with disabilities 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 aging individuals and individuals with disabilities 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. MR Community Services.** Provide services, other than those provided through the Medicaid waiver programs, to individuals with intellectual and developmental disabilities who reside in the community including independent living, employment services, day training, therapies, and respite.

**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 aging individuals and individuals with disabilities to maintain their independence and prevent institutionalization.

**Strategy 1-4-5. MR In-Home Services.** The MR 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 individual's disability and that directly support that individual 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 aging individuals 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 that 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-insurance payments for Medicaid recipients residing in Medicare (XVIII) skilled nursing facilities, Medicaid/Qualified Medicare Beneficiary (QMB) recipients, and 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 residents to relocate from nursing facilities back into community settings.

**Objective 1-7. Intermediate Care Facilities—MR.** Provide residential services and supports for individuals with intellectual and developmental

disabilities living in intermediate care facilities for persons with MR (ICFs/MR).

**Strategy 1-7-1. Intermediate Care Facilities (ICFs/MR).** The ICFs/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. State Supported Living Centers Services.** Provide specialized assessment, treatment, support and medical services in State Supported Living Centers and State Center programs for individuals with intellectual and developmental disabilities.

**Strategy 1-8-1. State Supported Living Center Services.** Provides direct services and support to individuals living in State Supported Living Centers. State Supported Living Centers provide 24-hour residential services for individuals with intellectual and developmental disabilities 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 Supported Living Centers. 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.

## 9.2.2 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.

### 9.2.3 Goal 3: Indirect Administration

*Assure the efficient, quality, and effective administration of services provided to aging individuals and individuals with disabilities.*

**Objective 3-1. General Program Support.**

**Strategy 3-1-1. Central Administration.** Provide executive direction and leadership, budget management, fiscal accounting and reporting, public information, state and federal government relations, internal and field auditing, and other support services such as facility acquisition and management, historically underutilized businesses, educational services, forms and handbook management, records management and storage, and direct support staff in programs in the headquarters office.

**Strategy 3-1-2. Information Technology Program Support.**

Provides technology products, services, and support to all DADS divisions including application development and support, desktop and LAN support and troubleshooting, coordination of cabling and hardware repair, mainframe and mid-tier data center processing and telecommunications.

**Strategy 3-1-4. Regional Administration.**

## 9.3 Department of Assistive and Rehabilitative Services

### 9.3.1 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 2013, 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.** 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 2013.

**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.** To provide services to Texas children ages 3-8 diagnosed with autism spectrum disorder.

### 9.3.2 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 2013, 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 2013.

**Strategy 2-2-1. DHH Services.** To administer an array of services to persons who are deaf or hard of hearing, including but not limited to: communication access, training, educational programs, testing interpreters, regulating interpreter certifications, and the STAP (Specialized Telecommunications Assistance Program) services

**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.

### 9.3.3 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 2013 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.

### 9.3.4 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.**

## 9.4 Department of Family and Protective Services

### 9.4.1 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.

### 9.4.2 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.** By 2013, 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 10.9 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.

### 9.4.3 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.

### 9.4.4 Goal 4: Adult Protective Services

*In 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 investigating in home settings and providing or arranging for services to alleviate or prevent further maltreatment.*

**Objective 4-1. Reduce Adult Maltreatment.** By 2013, deliver protective services to 75 percent of vulnerable adults at risk of maltreatment so that abuse/neglect/exploitation does not exceed 11.8 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.

### 9.4.5 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 2013, 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 43.9 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.

### 9.4.6 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.

## 9.5 Department of State Health Services

### 9.5.1 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.

## 9.5.2 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 through 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.

### 9.5.3 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 Disease.** 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.

### 9.5.4 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.**

## 9.5.5 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.**

## 9.5.6 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.



## **Chapter 10**

### **Technology Resources Planning**

This chapter responds to the Technology Resources Planning requirements in the “Instructions for Preparing and Submitting Agency Strategic Plans” developed by the Legislative Budget Board and the Governor’s Office of Budget, Planning, and Policy.

The chapter includes the following items for each of the five health and human services agencies:

- Part 1: Technology Assessment Summary, and
- Part 2: Technology Initiative Alignment.



## Part 1: Technology Assessment Summary

Department of Aging and Disability Services (DADS)	Department of Assistive and Rehabilitative Services (DARS)	Department of Family Protective Services (DFPS)	Department of State Health Services (DSHS)	Health and Human Services Commission Agency IT (HHSC-A)	Health and Human Services Commission Enterprise IT (HHSC-E)
Provide a brief description of the planned technology solutions that respond to the key factors that will affect the agency. Consider how those solutions align with the statewide technology goals reflected in the State Strategic Plan for Information Resources ( <i>Advancing Texas Technology</i> ).					
Collaborative efforts will continue between the HHSC agencies (HHS Enterprise, Commission IT, DADS, DARS, DFPS, and DSHS) and other entities for common infrastructure initiatives. Continual reviews of strategic roadmap to assure alignment with current technology trends that support changing business needs. Planned transformation of applications supported by the Commission to the servers at the state data centers.					
Provide agency descriptions related to each statewide technology goal listed below. The criteria for these descriptions appear after each goal and are labeled 1.a, 1.b, 2.a, and so forth.					
1.A Describe agency plans to strengthen and/or expand its capabilities through the initiatives described in Statewide Technology Goal 1.					
Statewide Technology Goal 1 is to “Strengthen and Expand the Use of Enterprise Services and Infrastructure”. DADS is one of 27 state agencies participating in shared Data Center Services through DIR’s contract with Team for Texas. The agency will continue to work with DIR and Team for Texas to complete transformation of current DADS servers.	Evaluate and participate in DIR services including, but not limited to: DIR Data Center Services, Northrop Grumman seat management contract (a DIR GODirect contract), DIR IT Staffing Services, and DIR TEX-AN network services.  Evaluate and participate in HHS Enterprise Managed Document Output (MDO) services and HHSC Enterprise	Enhance Capabilities of the Shared Infrastructure:  Participating in the Data Center Consolidation transformation process to simplify and reduce the number of hardware and software platforms in use.  Participating in enhancements to the HHS telecommunications	DCS Transformation resumes in July 2010	Continues to utilize state Data Center Services to provide infrastructure support and to host applications to meet requirements for business customers. CIT plans to continue its review of related applications and bring technology to current versions of software.  Will evaluate statewide portal initiatives to	Data Center Transformation process for replacement of outdated mainframe computer, improved bulk print/mailing capability; enhanced disaster recovery mechanism.  The Comptroller of Public Accounts (CPA) established an Enterprise Resource Planning (ERP) system to address common

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<p>The agency currently participates in the HHS enterprise shared e-mail messaging solution and partners with DARS to provide e-mail administration for DADS, DARS, and HHSC.</p> <p>Staff from the agency's Financial Services Division are also active participants in the State Enterprise Resource Planning (ERP) effort (ProjectONE) led by Comptroller of Public Accounts (CPA).</p>	<p>email system.</p> <p>Participating in the Comptroller's ERP Implementation (ProjectONE), as an option to replace HHSAS and HRMS, which feed into USAS at the Comptroller.</p>	<p>infrastructure which will assure a consistent quality and cost of service throughout the agencies.</p> <p>Will distribute new LAN equipment in key locations, making both WAN and LAN more accessible, enhancing performance, and increasing firewall security, which should provide better protection for DFPS equipment.</p> <p>Leverage Shared Applications</p> <p>Utilizes a Learning Management System which integrates information from the Enterprise Resource Planning system.</p> <p>Participating in the HHSC project to standardize e-mail and other collaboration technologies across the HHS enterprise to</p>		<p>determine whether our business needs are met with the offerings that are available. Collaboration tools are needed both internally and with external partners to assure secure collaboration on projects.</p> <p>Has migrated to the HHS Enterprise Messaging platform and will continue to leverage shared services associated with that offering.</p>	<p>statewide requirements with eight (8) State of Texas agencies. ProjectONE (Our New Enterprise), began in November 2009, includes HR/Payroll and Financials with collaboration among agencies. Article IX of SB1, 81st Legislative Session, appropriated \$9.4 million requested by HHS for an upgrade of the Health and Human Services Administrative System (HHSAS) HRMS to the CPA.</p> <p>Enterprise Messaging and Collaboration Solution. This initiative is migrating all HHS agencies' email systems to a consolidated Exchange System. It standardizes messaging and collaboration technologies across the enterprise to improve</p>

Department of Aging and Disability Services (DADS)	Department of Assistive and Rehabilitative Services (DARS)	Department of Family Protective Services (DFPS)	Department of State Health Services (DSHS)	Health and Human Services Commission Agency IT (HHSC-A)	Health and Human Services Commission Enterprise IT (HHSC-E)
		<p>improve productivity, performance and availability, provide for secure transmission of messages, protect against SPAM and viruses, improve collaboration capabilities, and deliver improved service levels with better uptime.</p> <p>Leverage the State's Purchasing Power</p> <p>Uses Deliverables-Based IT Services (DBITS) which makes eight services available for immediate purchase or contract at pre-negotiated lowest prices. DFPS also leverages the Information and Communications Technology (ICT) program for best value purchases.</p>			<p>productivity, performance and availability, security, and collaborative efforts.</p> <p>Enterprise Data Warehouse Business Intelligence will provide an enterprise data warehouse for the five HHS agencies that will contain client-centric information to provide reliable information to HHS executives, managers, agency analyst, clients, providers, and federal, state, and public data trading partners.</p> <p>The Texas Electronic Benefit Transfer (TxEBT) system, which delivers services to Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) clients, is currently operating on</p>

Department of Aging and Disability Services (DADS)	Department of Assistive and Rehabilitative Services (DARS)	Department of Family Protective Services (DFPS)	Department of State Health Services (DSHS)	Health and Human Services Commission Agency IT (HHSC-A)	Health and Human Services Commission Enterprise IT (HHSC-E)
					<p>unsupported database software and very old hardware. This project will migrate TxEBT to new hardware running on UNIX (IBM AIX) and move data center operations from DIR's Network Security and Operations Center (NSOC) to the new Austin Data Center operated by Team for Texas (TfT).</p> <p>Enterprise Eligibility systems (Including TIERS) - SAVERR (the System for Application, Verification, Eligibility, Referrals, and Reporting System), and TIERS (the Texas Integrated Eligibility Re-design System) collectively support IE (Integrated Eligibility) for HHSC. Both SAVERR and TIERS process eligibility applications and enrollment for Food</p>

Department of Aging and Disability Services (DADS)	Department of Assistive and Rehabilitative Services (DARS)	Department of Family Protective Services (DFPS)	Department of State Health Services (DSHS)	Health and Human Services Commission Agency IT (HHSC-A)	Health and Human Services Commission Enterprise IT (HHSC-E)
					Stamps (SNAP), TANF (Temporary Aid for Needy Families), Medicaid, CHIP (Children’s Health Insurance Program), Long-Term Care, and a myriad of other assistance programs that are legislatively mandated or requested by Program/Policy customers and/or trade partners, therefore supporting issuance of benefits to millions of Texas citizens in need. SAVERR is the legacy eligibility system that has well served the State for decades and continues to serve a majority of the State’s client population. SAVERR supports a single-channel business model that has since become obsolete. TIERS is the next generation EES (Enhanced Eligibility System). TIERS

Department of Aging and Disability Services (DADS)	Department of Assistive and Rehabilitative Services (DARS)	Department of Family Protective Services (DFPS)	Department of State Health Services (DSHS)	Health and Human Services Commission Agency IT (HHSC-A)	Health and Human Services Commission Enterprise IT (HHSC-E)
					<p>supports an enhanced (call-center) business model, multi-channel client access; face-to-face, telephone, fax, and self-service.</p> <p>TIERS is deployed upon a contemporary, web-based Service-Oriented Architecture (SOA), and is in various stages of implementation.</p>
<p>1.B Describe agency plans to strengthen and/or expand its capabilities through other initiatives that leverage enterprise or multi-agency services and infrastructure, including managed services, shared applications, internal consolidation efforts, and procurement strategies.</p>					
<p>The agency is actively increasing its use of DIR Deliverables-Based Information Technology Services (DBITS) and uses other contracts and services through the DIR Cooperative Contracts program to acquire software, hardware, equipment and services needed to meet core agency business needs.</p> <p>The agency also</p>	<p>Actively participating in the Comptroller's ERP Implementation ProjectONE, HHS Enterprise HCATS (Contract Administration and Tracking System) and HHS Enterprise Data Sharing Initiative.</p>	<p>Participates in the HHS Enterprise licensing programs for applications and software.</p> <p>Leverages the HHS contract with Software Contract Solutions, Inc. (SCS) to get the best rate possible for software.</p> <p>Participating in the Data Center</p>	<p>Enterprise Email Migration Planning through June 2010; tentatively plan to migrate August-October 2010.</p> <p>Enterprise Telecom Managed Services Project - second core to be installed at the DSHS Moreton Campus</p>	<p>Migrating telecommunication infrastructure to a managed services platform that will allow for client delivery services to be optimized utilizing current communications technology. This project is a comprehensive effort across the HHS</p>	<p>In October 2009, HHSC entered into a consultant contract with Software Contract Solutions, Inc. (SCS).</p> <p>SCS provides negotiation support services that address issues related to price, cost savings measures, risk exposure and overall total cost of ownership for information technology</p>

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<p>participates in the HHS Enterprise Subscription Agreement (ESA) with MicroSoft for desktop software, shares legacy applications such as CARE, SAVERR, and TIERS with other HHS agencies and plans to expand its use of the Avatar Client Records System also used by DSHS and maintained by HHSC.</p>		<p>Consolidation.                      Utilizes the available DBITS and ICT programs for competitive pricing procurement</p>		<p>enterprise.                      Negotiated a core PC seat management contract that is being leveraged by DSHS.                      Will continue to use outside specialists to negotiate deeper volume-based discounts on large procurements.</p>	<p>(IT) items. SCS's role is to take baseline offers at the point they are submitted to HHSC, and use its expertise to obtain maximum value for any agency within HHS.                      Strategic Contract Opportunities - HHS IT budgets include over \$250 million annually in contracts (e.g., Microsoft, Cognos, IBM Websphere, Seat Managed Computers). This does not include many program driven contracts with major IT components (e.g., MMIS, Convergys). A strategic roadmap is being built, from across the enterprise to ensure HHS purchasing power is being leveraged to it fullest. Information Technology input should also be included during RFO</p>

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					<p>development and review to ensure IT components of programmatic contracts are implemented to leverage purchasing options available through major HHS IT contracts (e.g., Oracle).</p> <p>Enterprise Messaging and Collaboration Solution. This initiative is migrating all HHS agencies' email systems to a consolidated Exchange System. It standardizes messaging and collaboration technologies across the enterprise to improve productivity, performance and availability, security, and collaborative efforts.</p>
<p>2.A Provide an update on the agency's progress in implementing strategies to align with the State Enterprise Security Plan.</p>					
Chapter 202 of Title 1 of the Texas Administrative	DARS Security Management is	The DFPS network is protected by tools and	Network Intrusion Prevention /Detection	Actively performing risk assessments to reduce	Planning a Data Loss Prevention (DLP)

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<p>Code (1 TAC 202) establishes information security standards for all Texas state agencies and universities. Texas Health and Human Services (HHS) reinforced this requirement with the publication of HHS Circular C-021 HHS Enterprise Information Security Policy and the Publication of Enterprise Information Security Standards. HHS Agency Information Security Officers (ISO), including DADS, are required to develop and implement an Information Security Program for their agency. Further, HHS agencies are required to develop and implement information security policies, standards, and guidelines that are consistent with and do not limit the effectiveness of the Enterprise Information Security</p>	<p>committed to the Department of Information Resources Enterprise Security Plan (ESP). Specific strategies aligning with the plan are listed below:</p> <p>Enhance current encryption practices,</p> <p>Convert unsecured file transfers to secure encrypted transmissions,</p> <p>Implement identity and access management systems,</p> <p>Improve risk assessment processes by using the DIR Information Risk Assessment tool.</p> <p>Conduct regular external and internal network vulnerability and penetration testing, and</p> <p>Introduce security methodology in systems development tools, practices, and training to ensure more effective security controls.</p>	<p>software under DFPS control, but the entire network connects to a much larger statewide system managed by the Department of Information Resources. DFPS participates with DIR in the planning and implementation of a shared approach for perimeter security and the sharing of information regarding new threats, especially those that target government networks. New network tools are being installed by DFPS to provide early warnings of intrusion. Incident response procedures are also being reviewed and updated to provide the fastest remediation of identified problems.</p> <p>DFPS conducts regular external network vulnerability and penetration testing and</p>	<p>System Deployment—to prevent and detect incidents of intrusion into the network and assist with incident response. July 2010</p> <p>PGP Whole Disk Encryption Deployment - to ensure confidential and sensitive data stored on the hard disk of all workstations are protected from unauthorized access. June 2010</p> <p>Network Access Control System Implementation - to ensure only users with security compliant devices access authorized resources.</p> <p>July 2010</p> <p>Web Application Vulnerability Scans - to assess web applications for issues impacting accessibility,</p>	<p>vulnerabilities using the DIR ISAAC tool and participates in the annual DIR Network Penetration and Vulnerability Testing. HHSC has implemented multiple Intrusion Prevention Systems to prevent and reduce vulnerability to cyber attacks. HHSC will continue to make enhancements in this area to accommodate the ongoing need for secure but robust internal and external communications and information exchanges. An Agency Security Plan has been developed which incorporates applicable state security policies, standards, and laws and applicable federal Requirements. Whole disk encryption has been implemented for agency desktops and laptops. The HHS</p>	<p>program. This aligns with Goals 1 and 2 of the State Enterprise Security Plan, to prevent cyber attacks and to reduce vulnerability to cyber attacks and other disruption. Through the DLP program, HHSC data will be classified and protected according to classification. The protection mechanisms will be in place for all data throughout its lifecycle, including in use, in transit, in storage, and finally at destruction. A strong emphasis will be placed on training end users to utilize tools such as encryption to protect sensitive agency information.</p> <p>Additionally, HHSC is formalizing their Enterprise Incident Response process,</p>

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<p>Policy. In compliance with these requirements, DADS published executive-approved Security Road Map, agency-wide standard operating procedures in the DADS IT Handbook, and provides regular security training of DADS staff.</p>		<p>assessments as outlined in the State Enterprise Security Plan.</p> <p>Other security measures in place that provide a high level of protection include:</p> <ul style="list-style-type: none"> <li>initiating current and ongoing statewide assessment activities;</li> <li>conducting statewide cyber security risk, vulnerability, and equipment assessments, which track strengths, weaknesses, and remediation activities;</li> <li>participating in technical cyber security training, security forums, seminars, and conferences;</li> <li>promoting cyber security awareness, training, education, and certification programs;</li> <li>periodically test and</li> </ul>	<p>confidentiality, integrity, quality and regulatory compliance. September 2009–August 2011</p>	<p>Enterprise Information Security Standards and Guidelines (based on TAC 202 requirements) have been adopted. HHSC is formalizing our Incident Response process, which aligns with Goal 3 of the State Enterprise Security Plan to respond and recover to minimize the impact of successful cyber attacks and disruptions. HHSC staff have previously and are currently participating in the DIR sponsored CSIRT training provided by Carnegie Mellon’s CERT (Computer Emergency Response Team). An online security awareness training program is in place for all agency staff. HHSC administers a virus prevention and incident reporting program that complies with the <i>State</i></p>	<p>which aligns with Goal 3 of the State Enterprise Security Plan. Goal 3 is to respond and recover to minimize the impact of successful cyber attacks and disruptions.</p> <p>The State Enterprise Security Plan (2007-2012, p.9) recognizes that “the greatest threat to our cyber networks stems from insiders - individuals who have authorized physical or electronic access to an organization’s information resources.” The Enterprise Identity Management solution prevents unauthorized access and terminates access immediately when employees leave or transfer within the HHSS. The solution also automates security policy in a uniform manner across applications and</p>

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		<p>exercise cyber security plans;                      including cyber security participation in emergency response exercises;                      requiring offline authentication immediately after boot up;                      application software encrypts the files that are most used by caseworkers; and                      special software tracks lost or stolen devices and automatically wipes the hard drive when detected through an Internet connection.</p> <p>DIR chose a DFPS staff member to attend the three week training program for developing a state Computer Security Incident Response Team (CSIRT). Through this effort, DFPS actively</p>		<p><i>Enterprise Security Plan.</i> HHSC leverages NSOC information sharing, analysis, and response processes and is utilizing the NSOC's NetForensics capabilities. HHSC staff participates in IT security forums, seminars, and conferences as outlined in the <i>State Enterprise Security Plan.</i></p>	<p>provides a secure connection for access.</p>

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		participates in the state Computer Security Incident Response Team to rapidly identify, contain, and recover from any attack or attempt to disrupt the state's critical IT infrastructure			
2.B Describe the agency's identity management strategies in place or planned.					
<p>The agency uses identify management systems provided by HHS Enterprise Security Management and by HHS Commission IT for DADS applications.</p> <p>The majority of DADS applications updated to web-based technology are using the HHS Enterprise Portal. DADS and HHS Enterprise Security plan to continue this strategy as new applications are developed and/or legacy systems are migrated to</p>	<p>Identify management strategies in place or planned:</p> <p>Single sign-on deployed in the DARS network, and</p> <p>Evaluating automated user provisioning and access management technologies (IAM) for an eventual implementation.</p>	<p>DFPS case numbers are based on unique identifiers not related to social security number or any other identifying information. DFPS organizational units involved in identity management functions include the Chief Operating Officer, Internal Audit, General Counsel /Legal Services, the Information Resources Manager, and the Information Resources Security Officer.</p> <p>Confidentiality and non-</p>	<p>To ensure account management through the proper identification of authorized users and establishment of conditions for account assignment and associated authorizations and access rights/ privileges based on valid need-to-know, least-privilege, and intended system usage.</p>	<p>The Security and Identity Management (Identity Vault, or IDV) provides access to, and security of, HHS information resources. It is the primary repository of identity accounts for HHS employees, contractors and partner employees who access secured HHS applications, providing consistently high level of secure, auditable access. <i>(IN PLACE)</i></p> <p>Oracle Connectivity and Audit: Establish</p>	<p>The Enterprise Identity Management solution provides the means for automated provisioning, de-provisioning, and user access management for 19 applications within the HHS Enterprise. As of May 2010, there were over 15,000 registered users which held over 22,000 application accounts. This solution interfaces with user repositories and systems that deal with user access in other agencies within</p>

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new technology.		disclosure agreements are required of all staff, contractors, vendors and business partners. Access to data is controlled by login permissions, and is provided based on job classification and the categorization of data. Information Security Awareness Training is provided to all users of Information Resources. HIPAA training is available to all users. All computers are scheduled to blank after a period of inactivity preventing unauthorized use or viewing of sensitive materials. DFPS is planning a method for encrypting mobile devices.		Identity Vault (IDV) connectivity to Oracle and institute User-Level audit trails. This includes the cradle-to-grave management of identities to include the auditing of all actions associated with this. <i>(IN PROGRESS)</i>  Identity Management - Security Permission Process: Create end-to-end identity-based, multi-step security access/request/approval process. This is a single system to provision access requests; will speed up current paper-based/multi-layer process. <i>(IN PROGRESS)</i>  GALSIGN link to Identity Vault (IDV): Link IDV HHSAS Employee ID to GALSIGN process in order to create users at the local office. This will	the HHS Enterprise and enables authentication, implements uniform security policies, allows for single sign on to applications as well as self service for tasks such as password resets, security question set up, user profile updates, and request for application access.  These solutions are reusable across other agencies within the HHS Enterprise and outside of the Enterprise. Currently the Texas Department of Agriculture uses this solution to manage an application that was legislatively transferred from HHSC.  Enablement of security policies including strong passwords, accessibility enhancements, and

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				remove the dependency on the Mainframe for user creation and allow for stronger password. ( <i>PLANNED</i> )	dormant account de-provisioning have been at the forefront of recent improvements. Planned initiatives include: recertification of application access on an annual basis and the continued expansion of the number of applications protected.
3.A Describe the agency's plans to expand or enhance access to its services and promote citizen engagement through online services and emerging technologies.					
During FY 2009, engaged a consultant to review its public-facing internet and surveyed public users to improve the visibility, usability, and effectiveness of its public web site. Improvements recommended by the consultant were implemented. An agency-wide, holistic, strategic assessment of legacy system modernization and	Because of the DARS Service Model, DARS does not participate in TexasOnline.com  DARS maintains an internet site which shares information with citizens regarding agency programs, services and performance reports and metrics.	Working on an application that provides additional information about the programs and the appropriate contacts for the public about Prevention and Early Intervention services available by county called LAP (Locally Available Programs). Childcare centers will soon be able to complete application forms entirely online	The Web Content Management System (WCMS) project is due to be completed in August 2010 and the System Remediation Project will be completed in August FY11. The New WCMS includes Web 2.0 and the DSHS Office of Communications is planning to use the Web 2.0 web services functionality. Also, the ability to serve content	Successfully implemented Interactive Voice Response (IVR) services for Medical Transportation Program (MTP) and the DHS WIC program. This is an automated service that allows callers to dial in and get "automated" information that provides status/and or direction. This allows citizens to obtain	Enterprise Eligibility Systems (Including TIERS) - SAVERR (the System for Application, Verification, Eligibility, Referrals, and Reporting System), and TIERS (the Texas Integrated Eligibility Re-design System) collectively support IE (Integrated Eligibility) for HHSC. Both SAVERR and TIERS process eligibility applications and

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<p>system consolidation is being considered. Enhanced access to on-line services and citizen engagement is a potential outcome of that assessment.</p>		<p>and submitters can monitor progress of their application online as well. DFPS tests any new or changed web page designs for usability. Caseworkers using tablet PC's and the Mobile Caseworker application have instant access to DFPS resources and can answer almost any question posed by clients instantaneously. Future plans include making some DFPS access pages available in Spanish as well as English</p>	<p>to mobile devices (cell phones, etc) will be implemented. DSHS uses GovDelivery for outreach to interested individuals via email when content on a web site changes.</p> <p>The WCMS project will improve service delivery to internal and external stakeholders by:</p> <p>Providing relevant, up-to-date, and easy-to-find online content.</p> <p>Improving the agency's ability to respond in a public health emergency.</p> <p>Improving the agency's ability to comply with EIR accessibility requirements.</p> <p>Improving health promotion and education.</p> <p>The System Remediation project</p>	<p>information in an expedited manner.</p> <p>Applications are being developed to be fully web-based and providing self-service to the citizens where appropriate, such as the medical transportation program. Telecom is being integrated with application software where possible to leverage interactive voice and software.</p>	<p>enrollment for Food Stamps/SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Aid for Needy Families), Medicaid, CHIP (Children's Health Insurance Program), Long-Term Care, and a myriad of other assistance programs that are legislatively mandated or requested by Program/Policy customers and/or trade partners, therefore supporting issuance of benefits to millions of Texas citizens in need. SAVERR is the legacy eligibility system that has well served the State for decades and continues to serve a majority of the State's client population. SAVERR supports a single-channel business model that has since become obsolete, and SAVERR</p>

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			<p>will remediate selected DSHS applications for:</p> <p>ERI Accessibility compliance.</p> <p>Migration from declining technologies to emerging ones.</p> <p>DSHS Communications is also implementing a robust web analytics tool that will allow us to measure, analyze and optimize the customer web experience.</p> <p>Created the <a href="http://www.TexasFlu.org">www.TexasFlu.org</a> website to provide information to the public and specific populations such as vaccine providers, health care professionals, child care/schools, employers, laboratories, and news media. The website also links to YouTube for an update on H1N1 presented by the DSHS</p>		<p>applications run against Unisys mainframe technology. TIERS is the next generation EES (Enhanced Eligibility System). TIERS supports an enhanced (call-center) business model, as well as multi-channel client access; face-to-face, telephone, fax, and self-service. TIERS is deployed upon a contemporary, web-based Service-Oriented Architecture (SOA), and is currently in various stages of implementation across the State.</p> <p>Health Information Technology - Embracing the Medicaid Information Technology Architecture (MITA) roadmap that the Centers for Medicare and Medicaid Services (CMS) requires for</p>

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			<p>Commissioner as well as other public health information videos.</p> <p>DSHS provides services via the TexasOnline Portal including vital statistics and regulatory services licensing.</p>		future spending to leverage State dollars.
3.B Describe initiatives planned or in process that will facilitate access to agency information and public data.					
<p>Participates in an HHS enterprise effort to improve accessibility of DADS internet and intranet. IT is pursuing funding to acquire tools and vendors through DIR's DBITS to facilitate implementation of accessibility standards. The agency is also developing an improved Employee Misconduct Registry (EMR) to make information available to perspective employers at facilities regulated by DADS.</p>	<p>Supporting the HHS Enterprise Data Matching Workgroup initiative.</p> <p>Constantly exploring new ways of sharing and delivering information to citizens on its public internet site.</p>	<p>Provides skip links on the top of all Web pages with different styles of sheet selection options for larger font and higher contrast. The DFPS Web site includes an "Accessibility" link to a Web page that contains the DFPS accessibility policy, contact information for the DFPS accessibility coordinator, and a link to the Governor's Committee on People with Disabilities Web site. In addition to</p>	<p>The Web Content Management System (WCMS) Project is due to be completed in August 2010 and the System Remediation Project will be completed in August FY11. The New WCMS includes Web 2.0 and the DSHS Office of Communications is planning to use the Web 2.0 web services functionality. Also, the ability to serve content to mobile devices (cell phones, etc) will be implemented. DSHS</p>	<p>Rewrite of Medical Transportation system to fully use telecom and application software.</p>	<p>Electronic Information Resources (EIR) Accessibility: is for all HHS agencies to reach compliance with provisions of Texas Government code and Rehabilitation Action of 1973 through a consolidated model that expands service provided by DARS to provide accessibility testing, training and consultation. And for agency identified testing tools licenses, staff and training.</p>

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		<p>Intranet and Internet searches, the DFPS web site also provides links to the DADS, DARS, DSHS, and the HHSC Internet and Intranet, plus the HHSC Extranet. DFPS has a strong presence on the HHS Electronic Information Resource workgroup and works in close relationship with DARS to ensure the accessibility of Web pages. DFPS has web pages scanned by an HHS tool to identify accessibility problems. The scanned reports have been used to identify issues and recommend modifications to the web pages. DFPS is in the process of including Spanish as well as English in web page construction.</p>	<p>uses GovDelivery for outreach to interested individuals via email when content on a web site changes.</p> <p>DSHS Communications is also implementing a robust web analytics tool that will allow us to measure, analyze and optimize the customer web experience.</p> <p>The WCMS project will facilitate access to agency information by providing an accessibility-compliant single online interface to the three major categories of user needs:</p> <p>Information/ Communication: announcements, data/statistics, educational materials, licensing info, etc.</p> <p>Tools: forms, manuals, directories, training,</p>		<p>Health Information Technology - Embracing the Medicaid Information Technology Architecture (MITA) roadmap that the Centers for Medicare and Medicaid Services (CMS) requires for future spending to leverage State dollars.</p> <p>The new Medicaid Eligibility and Health Information Services (MEHIS) system will replace the current paper Medicaid identification form with a permanent plastic card, automate eligibility verification, provide an electronic health record for all Medicaid clients, introduce e-prescribing functionality, and establish a foundation for future health information exchange for improved efficiency,</p>

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			<p>research support, etc.</p> <p>Services: online ordering (publications, birth and death certificates), licenses, volunteer registration, etc.</p> <p>The System Remediation project will facilitate access to agency information by:</p> <p>Implementing ERI Accessibility compliance in DSHS applications.</p> <p>Enhancing the interfacing capability with other agencies and business partners' applications by standardizing around emerging technologies.</p> <p>Participates in the HHSC 211 Call Center and Online Information program (3) DSHS created a temporary call center during the hurricanes of 2008 to</p>		<p>continuity of care, and health outcomes. HHSC posted a request for proposals (RFP) in December 2008, for MEHIS, which will include implementation and operation services. The target implementation of the MEHIS system is January 2011.</p>

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			<p>assist citizens in locating family members who had been relocated</p>		
<p>4.A Describe agency plans to implement or enhance workplace productivity and to leverage collaboration tools.</p>					
<p>Hiring a consultant through DBITS to perform an independent assessment of the IT division to include organizational structure and staffing in terms of skills and capacity required to support demand, and overall efficiency and effectiveness. The agency is striving to reduce dependency on staff augmentation contractors for daily IT operations and instead use DBITS vendors for projects with a scheduled end date.</p>	<p>Moving the Application Development organization into the (IBM) Rational suite (System Architect, Requisite Pro, ClearCase, ClearQuest, etc.) including development, configuration, change, and release management infrastructure, consistent with the HHS Enterprise.  Expansion of SharePoint accessible collaborative and intranet use throughout the agency.  Enhance workplace productivity by leveraging technology to support programs such as Telework and mobile workers.</p>	<p>Utilizes the latest innovations in technology to increase and enhance workplace productivity. By leasing desktop computers on a three year rotation DFPS guarantees that desktop technology is no older than three years at any given time. Mobile technologies in the form of Mobile Caseworker utilize tablet computers to provide caseworkers with a higher quality and more viable mobile service delivery model. This allows caseworkers full access to all LAN</p>	<p>Active Directory Completion in January 2010 has enabled use of SharePoint which is gradually being adopted by individual units.  Qwest for web-meetings is being used as well as some videoconferencing. GoToMyPC Meeting is also being used  GoToMyPC is available to cover specific Disaster Recovery requirements for alternate worksites.</p>	<p>Reviewing collaboration tools, such as SharePoint, and preparing a strategy to expand SharePoint's collaborative and intranet use throughout the enterprise.  Applications are built with business in mind, partnering with business owners and are tuned to facilitate the daily operational workflows of agency program requirements.</p>	<p>Expansion of SharePoint accessible collaborative and intranet use throughout the agency.  Enterprise Messaging and Collaboration Solution. This initiative is migrating all HHS agencies' email systems to a consolidated Exchange System. It standardizes messaging and collaboration technologies across the enterprise to improve productivity, performance and availability, security, and collaborative efforts</p>

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		applications and tools, improving the timeliness and accuracy of support to clients of DFPS in the field.			
4.B Describe agency strategies to develop and deploy applications more efficiently (i.e., through Cloud Computing, Software as a Service, Application Toolkits, Legacy System Modernization).					
Currently pursuing legacy system modernization by: migrating DADS supported applications off of the HHS Unisys mainframe by the end of FY 2010; converting those applications to web-based server environments; and identifying an additional 10 applications which must be migrated from outdated, unsupported technology to be transformed by Team for Texas. Future plans for migrating DADS supported applications off of the IBM mainframe are	Will continue to consider these as options. However, there are no current plans to use Cloud Computing and Application Toolkits. The DARS IR Quality Center application is utilizing Software as a Service. ReHabWorks (RHW) is a legacy system modernization effort to replace two legacy case management systems with a single web-based system.	Continues to explore different tools and strategies to more efficiently develop and deploy custom systems. DFPS has integrated the use of application toolkits such as Devexpress and APEX to streamline development. Additionally, DFPS has integrated Agile methodologies into a standard SDLC (Software Development Lifecycle) approach. Finally, DFPS has increased the inclusion of business analysis into software	Adopted a standards based architecture and established the Center for Service Design & Architecture to ensure compliance. Other strategies for legacy system modernization include system retirement, software remediation, combining systems, and creating a blueprint architecture for registries. DSHS IT has created an ARRA-funded Strategic Health Information Partnership (SHIP) initiative which is expected to result in an enterprise-wide	Currently reviewing our local office infrastructure due to the migration of the TIERS application. This will allow HHSC to design and implement an updated and secure infrastructure that will support the automated management of local offices utilizing remote desktop management and virtual network and server components. This approach promotes a more optimal use of these components as they can be leveraged by co-located agencies.	Replacement of SAVERR, the legacy eligibility system that has well served the State for decades and continues to serve a majority of the State's client population. SAVERR supports a single-channel business model that has since become obsolete, and SAVERR applications run against Unisys mainframe technology. TIERS is the next generation EES (Enhanced Eligibility System). TIERS supports an enhanced (call-center) business model, as

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<p>yet to be defined.</p> <p>As mentioned in 3.A, an agency-wide, holistic, strategic assessment of legacy system modernization and system consolidation is being considered. The potential for cloud computing is a possible outcome of that assessment, if approved by agency management.</p>		<p>development processes which has lead to increased usability by the agency.</p> <p>Mobile Caseworker gives caseworkers instant access to all tools and information available on the LAN using tablet computers. This portability allows caseworkers to carry the computer with them into homes, schools, and businesses. IMPACT, CLASS, and CLASSMate are examples of developing and improving applications for field use. These applications are beginning to use Internet interfaces to allow not only caseworkers but also the clients of DFPS access to tools and information.</p>	<p>health information architecture.</p> <p>Looking at options for SaaS and Cloud Computing (e.g., Salesforce). One branch is using CodeSmith, a template-based code generator tool and are about to purchase Telerik UI Controls and Automated Testing tools.</p>	<p>Exploring the use of cloud computing as an alternative to state data centers to improve efficiencies and provide redundancy for critical applications. Applications are constantly reviewed for appropriate upgrades to current technologies, including those that promote interoperability.</p>	<p>well as multi-channel client access; face-to-face, telephone, fax, and self-service. TIERS is deployed upon a contemporary, web-based Service-Oriented Architecture (SOA), and is currently in various stages of implementation across the State.</p>

Department of Aging and Disability Services (DADS)	Department of Assistive and Rehabilitative Services (DARS)	Department of Family Protective Services (DFPS)	Department of State Health Services (DSHS)	Health and Human Services Commission Agency IT (HHSC-A)	Health and Human Services Commission Enterprise IT (HHSC-E)
4.C Describe agency strategies to enhance information asset management practices.					
<p>Continue the agency's current asset management practices for now.</p>	<p>Based on Gartner recommendations, DARS is assessing Configuration Management Database (CMDB) best practices on best practices to implement in our environment; and to enhance Data Life Cycle Management.</p> <p>DARS is moving the DARS Intranet content into an accessible SharePoint template; creating a type of content management system and a process to review, update, archive and retire data from legacy intranet sites.</p> <p>DARS plans to implement SAS Business Intelligence (BI) suite of tools to augment its ability to analyze and mine data for business</p>	<p>Currently refining and enhancing its asset management policies to include software asset management processes, in concert with HHS Enterprise efforts and leadership regarding software asset management.</p>	<p>Implemented Active Directory and is in the planning process of implementing MS System Center Configuration Manager to enable asset management. DSHS is working with the other HHS agencies to develop a strategy and toolset for software asset management.</p>	<p>Currently reviewing tools that will allow for a more comprehensive view of the assets that have been deployed for desktop support. This will allow us to track the assets and service the users as needed.</p>	<p>Software Asset Management - Enterprise software asset management would improve efficiency in software purchases. An enterprise workgroup to make enterprise-wide recommendations has formed. Various asset management tools are being examined.</p> <p>Strategic Contract Opportunities - HHS IT budgets include over \$250 million annually in contracts (e.g., Microsoft, Cognos, IBM Websphere, Seat Managed Computers). This does not include many program driven contracts with major IT components (e.g., MMIS, Convergys). A strategic roadmap to guide purchasing in</p>

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	partners.				HHS is beginning. This will ensure HHS purchasing power is being leveraged to it fullest. Information Technology input should also be included during RFO development and review to ensure IT components of programmatic contracts are implemented to leverage purchasing options available through major HHS IT contracts (e.g., Oracle).
4.D Describe agency practices or plans to enhance the use and sharing of information with agency business partners.					
The agency is currently pursuing an Abuse, Neglect, and Exploitation (ANE) Database project in partnership with DFPS as required by Senate Bill 643, 81 <sup>st</sup> Texas Legislative Session.	As part of ReHabWorks development, DARS will improve control (security), quality and capability of interfaces with various trading partners, service providers, and other agencies.	DFPS currently participates in multi-agency business services with: Health and Human Services (HHS) Children’s Bureau of Administration of Children & Families	Proposed a project to acquire and implement enterprise class technology for the purpose of managing consent and authorization business rules related to public and client access to health data across all	Taking steps to ensure that all electronic transfers with sensitive data are secured through encryption or other secure methods	Enterprise Data Warehouse (EDW) Business Intelligence will be an enterprise data warehouse for the five HHS agencies that will contain client-centric information to provide reliable information to HHS

Department of Aging and Disability Services (DADS)	Department of Assistive and Rehabilitative Services (DARS)	Department of Family Protective Services (DFPS)	Department of State Health Services (DSHS)	Health and Human Services Commission Agency IT (HHSC-A)	Health and Human Services Commission Enterprise IT (HHSC-E)
	<p>DARS utilizes GIS to evaluate how to optimally deliver services to our consumers.</p> <p>DARS is supporting the HHS Enterprise Data Matching Workgroup initiative.</p>	<p>through Foster Care and Adoption Reporting Information (AFCARS), and the Voluntary reporting of National Child Abuse and Neglect Data System (NCANDS).</p> <p>Health and Human Services Commission (HHSC): Foster Care SAVERR Medicaid sends files to HHSC to verify Medicaid information. Data from the APS and CPS case reviews is collected and the results are available to HHSC. Title XIX Eligibility communicates to match DFPS clients on SAVERR. Child Care Licensing Automated Support System (CLASS) interfaces for Fee Notices for facilities. Observance Reports for the HHSC Food Program, and the report of Facility</p>	<p>DSHS business systems. The benefit is protection of health data for which DSHS serves as custodian and/or owner. Implementation of a single technology initiative eliminates siloed approach to management of client consent and owner authorization which would be more costly.</p>		<p>executives, managers, agency analyst, clients, providers, and federal, state, and quasi-public data trading partners.</p> <p>The EDW project is in response to S.B. 1188 and H.B. 2292, which require the development of a comprehensive data warehouse capability and the consolidation of HHS functions. The project scope is to develop an enterprise data warehouse for the five (5) HHS agencies that will contain client-centric information to provide reliable information to HHS executives, managers, agency analysts, clients, providers, and federal, state, and quasi-public data trading partners. The warehouse is primarily focused on becoming a foundation for decision</p>

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		<p>Changes is used by HHSC in determining facilities that qualify for the HHSC Food Program.</p> <p>Comptroller of Public Accounts (CPA): Reports which originate at CPA send employee data extracts for employee and mail code information.</p> <p>Department of Public Safety (DPS): DFPS interfaces with DPS for Criminal History checks</p> <p>DADS: DFPS and DADS share information on facility investigations completed during the prior month.</p> <p>Texas Attorney General (AG): IMPACT receives reports of court ordered child support for children in foster care.</p> <p>Texas Youth</p>			<p>support analysis, data mining, and enterprise-wide management information reporting. Geographic information analysis is also a required feature of the warehouse. Project objectives will demonstrate a marked improvement in analytical capability, increased processing speed, greatly reduced fraud, and compliance with state and federal regulations.</p>

Department of Aging and Disability Services (DADS)	Department of Assistive and Rehabilitative Services (DARS)	Department of Family Protective Services (DFPS)	Department of State Health Services (DSHS)	Health and Human Services Commission Agency IT (HHSC-A)	Health and Human Services Commission Enterprise IT (HHSC-E)
		<p>Commission (TYC): IMPACT sends and receives data to TYC to recoup IV-E eligibility federal money for TYC.</p> <p>Texas Juvenile Probation Commission (JPC): IMPACT sends and receives data to JPC to recoup IV-E eligibility federal money for JPC.</p> <p>Third Party Reviewer Interface: IMPACT sends and receives information from Youth for Tomorrow regarding children in foster care whose level of care needs to be established or reviewed.</p>			
<p>Note:                      FTE constraints limit the inclusion of non-mandated projects that are necessary to maintain minimum services, keep pace with</p>					

Department of Aging and Disability Services (DADS)	Department of Assistive and Rehabilitative Services (DARS)	Department of Family Protective Services (DFPS)	Department of State Health Services (DSHS)	Health and Human Services Commission Agency IT (HHSC-A)	Health and Human Services Commission Enterprise IT (HHSC-E)
<p>evolving standards, increased security requirements, emerging technology, unplanned projects imposed by oversight agencies, and enhanced consumer services. In addition, the increase of FTEs in State Schools and State Offices places an extra burden on the support staff within Infrastructure Operations.</p>					

## Part 2: Technology Initiative Alignment

Technology Initiative Alignment for the Department of Aging and Disability Services (DADS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
Data Center Transformation	3.1	1.1	Current	Consolidation of old end-of-life servers on to new supported technology platforms. Achieving economies of scale for server administration across the agency and the standardization of hardware.	Innovation
E-Mail Messaging		1.1	Current	Continued participation in the HHS enterprise e-mail messaging system.	Benchmarking
Enterprise Resource Planning (ERP) led by Comptroller of Public Accounts (CPA)		1.1	Current	Continue participation by Financial Services staff in state-wide planning effort.	Innovation
Identity Management Initiatives	3.1	2.2	Current	Ensure agency standardization of access to the business applications and adhering to state federal standards to become compliant with state and federal security rules.	Best Practice
Security Program		2.2	Current	Maintain agency Security Roadmap, continue develop of Standard Operating Policies/Procedures, and presentation of	Best Practice

Technology Initiative Alignment for the Department of Aging and Disability Services (DADS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
				Security Awareness Program.	
Independent Assessment of IT Division		1.1	Current	The agency is hiring a consultant through DBITS to perform an independent assessment of the IT division to include organizational structure and staffing in terms of skills and capacity required to support demand, and overall efficiency and effectiveness. The agency is striving to reduce dependency on staff augmentation contractors for daily IT operations and instead use DBITS vendors for projects with a scheduled end date.	Innovation
An agency-wide, holistic, strategic assessment of legacy system modernization and consolidation, consumer engagement and on-line services		1.2 3.1 3.2 4.1 4.4	Planned	An agency-wide, holistic, strategic assessment of legacy system modernization and consolidation, consumer engagement and on-line services is being considered and is subject to approval by agency executives.	Innovation
Application Remediation Program	3.1	1.1	Current	Remediate several mission critical applications that reside in unsupported and outdated technologies to supported and current technologies.	Best Practices
Electronic and Information Resources (EIR)		3.1	Current	Procurement of tools and training for application and web developers to comply with Agency	Best Practice

Technology Initiative Alignment for the Department of Aging and Disability Services (DADS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
				standards and provide accessible resources and services to DADS customers with disabilities.	
Governance	3.1	4.1	Current	Governance is a prescribed method for the executive leadership of an organization to identify, select, and prioritize projects that comprise the organization's portfolio of projects using project proposals and business cases. Promotes efficient / economical use of limited staff resources, fiscal accountability, executive buy-in of IT project selections / priorities, achievement of mandated projects, alignment with agency strategic goals, and oversight of the selected portfolio to help ensure return on investment.	Best Practice
Infrastructure Improvements at State Supported Living Center (SSLCs)	3.1.	1.1	Current	Improved communication tools for the SSLC employees, clients, and clients' families including by: reducing cross talk on outside copper trunks which impairs privacy on conversations concerning patient records; installing reliable incoming and outgoing trunks; providing reliable voicemail system to provide dependable phone service; and reducing reduction of busy signals, static and hum on copper trunks lines.	Innovation

Technology Initiative Alignment for the Department of Aging and Disability Services (DADS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
Enhanced Reporting and Tracking Systems to Improve Patient Care and Safety in DADS-Owned or Regulated Facilities	3.1	4.4	Current	<p>Upgrade of the Employee Misconduct Registry (EMR) to track the due process of employees' misconduct referrals or individuals working or applying to work in long term care facilities, home health agencies and waiver programs. The system is also used by long term care facilities, agencies and the general public to track confirmed cases of misconduct by these persons. DADS regulated facilities and agencies are also required to perform an annual check of these registries via the Employability Checks database on the DADS website.</p> <p>The Legislature has mandated DADS to collect, maintain, and report data related to the investigation and prevention of abuse, neglect, and exploitation (ANE) of individuals who reside in a publicly or privately operated ICF-MR or receive DADS 1915(c) waiver services. Creation of a database that includes this data and the results of regulatory investigations or surveys, performed by DADS, of these facilities and programs will improve this process.</p>	Innovation

Technology Initiative Alignment for the Department of Assistive and Rehabilitative Services (DARS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
1. Data Center Services (DCS)	01 - 1 01 - 2 01 - 3 02 - 1 02 - 2 02 - 3 04 - 1 04 - 2 04 - 3 04 - 4	01 - 1	Current	The State of Texas spends approximately \$1.8 billion annually on information and communications technologies. DCS leverages economies of scale, modernizes the technology infrastructure, enhances information security levels, improves disaster recovery capabilities, provides the flexibility and agility to meet changing business requirements and provides services and service levels that meet the unique needs of each agency.	Best Practice as DCS leverages economies of scale for DARS.
2. ReHabWorks	02 - 1 02 - 3	04 - 2	Current	Provides broader access to consumer information by establishing a consolidated agency database. That is, one accessible application used by both the Rehabilitative Services and Blind Services divisions.  Streamlines common reporting processes by combining into an agency data warehouse one source of information – as opposed to merging from various reporting structures.  Creates potential savings for IT cost of hardware, software and support of two systems.	Innovation.  The DARS ReHabWorks application follows accessibility guidelines as stated in Section 508, the Texas Administrative Code – Chapters 206 and 213, Texas Government Code 2054.116 and Web Content Accessibility Guidelines 1.0.  Additionally, one application will now support the Division of

Technology Initiative Alignment for the Department of Assistive and Rehabilitative Services (DARS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
					Rehabilitative Services as well as the Division of Blind Services.
3. Seat Management	01 - 1 01 - 2 01 - 3 02 - 1 02 - 2 02 - 3 04 - 1 04 - 2 04 - 3 04 - 4	01 - 3 04 - 1	Current	<p>Miscellaneous hardware and software purchases and service contracts will keep software licenses current and replace hardware that will be at the end of its life, plus some additions required by changing needs.</p> <p>In this way, DARS will be up-to-date on all software products critical to its agency operations.</p> <p>This project will also provide tools (which includes adaptive and accessibility software and hardware) agency personnel require for continued support of blind services, rehabilitation services, services for deaf and hard of hearing and services for children.</p>	Best Practice for reasons shown in the Anticipated Benefits column.
4. Infrastructure and Development Platform Refresh	All objectives	01 - 1 01 - 3 03 - 1 04 - 1 04 - 2 04 - 4	Current	<p>Miscellaneous hardware and software purchases and service contracts will keep software licenses current and replace hardware that will be at the end of its life, plus some additions required by changing needs.</p> <p>In this way, DARS will be up-to-date on all software products critical to its agency</p>	Best Practice for reasons shown in the Anticipated Benefits column.

Technology Initiative Alignment for the Department of Assistive and Rehabilitative Services (DARS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
				operations.  This project will also provide tools (which includes adaptive and accessibility software and hardware) agency personnel require for continued support of blind services, rehabilitation services, services for deaf and hard of hearing and services for children.	

Technology Initiative Alignment for the Department of Family and Protective Services (DFPS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
Desktop Services Lease	1, 2, 3, 4, 5	2, 3, 4	Current	Replacing desktop computers on a regular schedule ensures that DFPS staff will continue to have computers that are capable of operating the more current computer software and peripheral hardware that will allow them to keep up with program changes and legislative mandates.	DFPS has engaged in a lease which replaces desktop computers every three years. This ensures that computers at the end of their lifecycle are replaced in a timely manner keeping DFPS users current in technology practices.
IMPACT Operational Enhancements	1, 2, 3, 4, 5	2, 3, 4	Current	This project involves continued enhancements of the web-enabled Information Management Protecting Adults and Children in Texas (IMPACT) system,. These enhancements are necessary to respond to federal requirements and the legislative mandates to improve system usability and to continue effectively supporting service delivery.	DFPS continues to move toward more Internet based applications, including the ability for the public to submit childcare application forms and the ability for them to check online the progress of that application.
Tablet PCs for Mobile Caseworker	2,4,5	2,3,4	Current	This project is designed to support quality casework through the use of tablet PCs; improving connections between caseworkers and the DFPS network; providing access to	DFPS provides services to clients in timely and efficient methods by using tablet PCs.

Technology Initiative Alignment for the Department of Family and Protective Services (DFPS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
				tools and information; and allowing timely services to be provided to DFPS clients.	
Software License	1, 2, 3, 4, 5,	1, 2, 3, 4	Current	DFPS maintains current Microsoft software licenses by participating in the HHSC Microsoft Enterprise Subscription Agreement (ESA). Standardizing Microsoft Office across DFPS and other HHS agencies allows unimpeded communication between agencies providing better access to information and services for DFPS clients.	
Data Center Consolidation	1, 2, 3, 4, 5	1, 2, 3, 4	Current	This is a centralized statewide project which ensures availability of DFPS resources on a 24 X 7 basis, allowing access to data by caseworkers to deliver needed services to clients.	

Technology Initiative Alignment for the Department of State Health Services (DSHS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
Accessibility Remediation Project	All Objectives	3.1 3.2 4.3 4.4 HIE	Current	This project will provide Department of State Health Services (DSHS) Web pages, applications, and other electronic information resources (EIR) compliance with federal and State Legislative mandates and Texas Administrative Code (TAC) rules that require these resources to be accessible to citizens, trading partners and employees with various disabilities.	Best Practice: Promote the use and sharing of public health related information.
Automated Medication Administration Records System (AMARS) Project	Objective 2-2 Provide Behavioral Health Services	4.1 4.2 4.3 4.4 HIE	Current	Help ensure the safe administration of medications in state hospitals. Help ensure the correct medication and dosage prescribed by the physician is administered to the right patient at the right time.	Best Practice: Pursue Leading Edge Strategies for Application Deployment; Promote the use and sharing of public health related information.
Clinical Management for Behavioral Health Services (CMBHS) Phase 4 Project	Objective 2-2 Provide Behavioral Health Services	4.1 4.2 4.3 4.4 HIE	Current	The anticipated outcomes of the CMBHS, Phase Four implementation will be DSHS's enhanced ability to collect and disseminate information vital to addressing public health issues in a timely manner that will result in more positive healthcare outcomes. CMBHS – Phase Four will align with national and state Health Information Technology/Health	Best Practice: Pursue Leading Edge Strategies for Application Deployment; Promote the use and sharing of public health information.

Technology Initiative Alignment for the Department of State Health Services (DSHS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
				<p>Information Exchange initiatives enhancing data system compatibility needed to implement programmatic and data exchange mandates from all levels of government.</p> <p>The outcome of this project will be a system in which provider organizations are more accountable to the State of Texas for the funding they receive, as DSHS oversight of service delivery and billing will be conducted using real time data without the need for statewide travel or shipping to review paper records.</p>	
Health Registries Improvement (HRI) Project	Objective 1-2 Infectious Disease Control, Prevention and Treatment	3.1 3.2 4.2 4.3 4.4 HIE	Current	<p>DSHS supports multiple Texas Registries that share data with National Registries sponsored by Federal Funding Partners.</p> <p>This project will provide a blueprint(s) for a model registry and/or registries. Health Registry Improvement Project target objectives are: (1) Establish Standard Technology for State Disease Registry where DSHS is primary authority (2) Establish Shared Technology for State Disease Registry where DSHS supports external partners (3) Adopt State Standard for Disease Registry to which external partners can build (4) Adopt a Single and Agile Interface to</p>	Best Practice: Pursue Leading Edge Strategies for Application Deployment; Promote the use and sharing of public health information.

Technology Initiative Alignment for the Department of State Health Services (DSHS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
				support organizations business requirements.	
Trauma Registry Improvement System (TRIS) roiect	Objective 1-2 Infectious Disease Control, Prevention and Treatment	3.2 4.2 4.3 4.4 HIE	Current	Compliance with the National EMS Information System (NEMSIS) and the National Trauma Data Bank (NTDB) database standards and information requirements. Provision of Trauma related information and data to key stakeholders, including the Governor's EMS and Trauma Advisory Council. Interoperability with other State and Federal Registries.	Best Practice: Pursue Leading Edge Strategies for Application Deployment Promote the use and sharing of information.
Women Infants and Children (WIC) Information Network (WIN) Evolution Project	Objective 2-1 Provide Primary Care and Nutrition Services	3.1 3.2 4.2 4.3 4.4 HIE	Current	Improved Agency (WIC) customer service; maximized new technology for increased system functionality; strengthened controls and accountability of WIC related data for reporting purposes; help minimize the potential of fraud and abuse in the program;. compliance with Federal rules and reporting requirements.	Best Practice: Pursue Leading Edge Strategies for Application Deployment Promote the use and sharing of information.
Transformation and consolidation of agency data center operations into the State Data Center	All Objectives	1.1 1.2	Current	Enhanced agency computing environment capabilities and economies of scale through the use of a shared infrastructure and resources (Enterprise Resource Planning).	Best Practice: Enhance capabilities of shared infrastructure and enterprise resource planning (ERP)
DSHS Core Network Upgrade	All Objectives	1.1	Current	This infrastructure project will enhance data communications reliability and availability and will ensure improved performance across the	Best Practice: Expand and enhance access to

Technology Initiative Alignment for the Department of State Health Services (DSHS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
				DSHS network in a secure environment.	agency services
Desktop Hardware/Technology Refresh Project	All Objectives	1.3 4.1	Current	Increased productivity resulting from more efficient desktop hardware and software. Increased security due to current technology and increased ability to manage the desktop remotely (patches, push security software)	Best Practice: Leverage the state's purchasing power and enterprise resource planning (ERP)
IT Server Refresh (pre-transformation)	All Objectives	1.1 1.3	Current	Improved application reliability, availability, and performance in a secure environment	Best Practice: Leverage the state's purchasing power and enterprise resource planning (ERP)
Health Information Technology for Economic and Clinical Health HITECH Project – State Medicaid Health Information Technology (HIT)Plan SMHP	HHSC Objective?	4.3 4.4	Current	The assessment and planning of the State Medicaid HIT Plan (SMHP) Planning project will enable the implementation of advanced technology to streamline administrative systems and reporting requirements for health providers, increase the efficiency and timeliness of DSHS-generated reports to stakeholders, the Texas Legislature, and other entities, and improve coordination of information between programs within the Department. It will also align future Public Health Information Technology Architecture (PHITA) requirements and designs to the state and federal Medicaid Information Technology Architecture (MITA).	Best Practice: The SMHP Planning project will provide input needed to develop a State Medicaid HIT Plan that describes the State's plan for its Medicaid incentive program, including a description of how HHSC intends to identify eligible providers, make payments to eligible providers, ensure adequate programmatic oversight of the incentive

Technology Initiative Alignment for the Department of State Health Services (DSHS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
					payments, and educate and encourage providers to adopt certified EHR technology.
Health Information Technology for Economic and Clinical Health HITECH Project  Strategic Health Information Partnerships (SHIP) – Planning	All Objectives	4.3 4.4	Current	<p>The Strategic Health Information Partnerships (SHIP) Planning project will facilitate the implementation of advanced technology to streamline administrative systems and reporting requirements for health providers, increase the efficiency and timeliness of DSHS-generated reports to stakeholders, the Texas Legislature, and other entities, and improve coordination of information among programs within the Department.</p> <p>SHIP will be composed of several projects that together will provide the formation of a comprehensive solution in which patient records can be located across existing organizational and system silos and properly linked in a secure manner to enable a record that is suitable for sharing across all points of care.</p>	Best Practice: Health information technologies such as Electronic Health Records (EHRs), Personal Health Records (PHRs), electronic prescribing (eRx), Healthcare Information Systems (HIS), and Electronic Behavioral Health Records (E-BHRs) each provide the opportunity to contribute to improvements in information access at many points of care. Providing the processes and technical framework for the integrated use of such tools is critical to enabling the Texas healthcare provider community to achieve the

Technology Initiative Alignment for the Department of State Health Services (DSHS)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
					goals of EHR of "meaningful use".

Technology Initiative Alignment for the Health and Human Services Commission (HHSC)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
<b>Medicaid Information Technology Architecture (MITA) Initiatives:</b> Oversee the Texas Medicaid Management Information Systems (TMMIS) compliance with CMS' directives regarding MITA. Texas Medicaid Self Assessment, Tx Medicaid Future State and to-be road map, data governance and data modeling.	Objective 1-3. HHS Consolidated System Support Services.	3.1	Completed 2/23/2010	Obtain 90/10 enhanced funding on MITA aligned projects; Ensure HHS IT projects conform with MITA direction to use standards-based technology including Service-oriented Architecture (SOA), Health Level 7, and X-12 transaction standards	Innovation: MITA initiative seeks to move state Medicaid programs toward inter-operability through the use of standards based technology.
<b>Claims Adjudication System Procurement:</b> Procure a new Claim Adjudication process utilizing national code sets (ICD-10, NPI).	Objective 1-3. HHS Consolidated System Support Services.	3.1	Planned	Medicaid will have a claims adjudication system that aligns with business processes and functionality outlined in the HHSC MITA roadmap, implements ICD-10, increases flexibility by removing crosswalks currently in place (which maintain the state's reliance on "home grown" code) instead of utilizing national code sets mandated by HIPAA, and improves eligibility interfaces. Medicaid will be able to take advantage of many enhanced federal funding opportunities.	Innovation: Implementing new code sets.
<b>Medicaid Eligibility and Health Information System:</b> Improve client service through improved eligibility verification and electronic health record information. Project	Objective 2-1. Medicaid Health Services.	3.2	Current	Eliminate cost of printing monthly Medicaid IDs and provide near real-time eligibility verification via a more permanent plastic magnetic stripe card. Additionally, the MINT Electronic Health Record will provide a rudimentary claims-based	Innovation: Texas would be the first state to provide an Electronic Health Record to all Medicaid recipients.

Technology Initiative Alignment for the Health and Human Services Commission (HHSC)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
components include: <ul style="list-style-type: none"> <li>• Replace monthly paper Med-Id card with more permanent plastic swipe card.</li> <li>• Eligibility verified via HIPAA compliant transaction.</li> <li>• Electronic Health Record claims based information for client available via swipe card</li> </ul>				health history to providers that includes medical claims/encounters and prescription drug information. Providers accessing this information will be able to potentially eliminate duplicative services and harmful drug interactions because they have access to client health history.	
<b>Enterprise-wide Assessment of ICD-10 Implementation Impacts:</b> Develop RFP and APD, evaluate proposals, select vendor, and provide technical support/oversight of HHS-wide assessment of impacts in implementation of ICD-10.	Objective 2-1. Medicaid Health Services.	3.2	Current	More accurate payment for new procedures. Fewer rejected and fraudulent claims. Better understanding of new procedures. Improved disease management. Per the Rand report, this results in a savings of \$700-7,700M industry wide over a ten year period. Improved coordination of system changes through advanced identification of dependencies and interface requirements.	Innovation: Implementing new code sets which will allow for more accuracy, and consistency, of payment for new procedures.
<b>Medical Transportation Program - Customer Service Strategic Initiative:</b> Implement nine telecom tools to improve the Medical Transportation Program's customer service experience, improve call metrics to increase compliance with the Frew judgment, aid employee retention and improve infrastructure	Objective 2-2. Other Medicaid Services.	1.2 4.1	Current	Improve MTP customer service experience and call metrics to increase compliance with the Frew judgment. Aid employee retention and improve infrastructure reliability.	Benchmarking: Measure client call metrics, employee retention and infrastructure reliability

Technology Initiative Alignment for the Health and Human Services Commission (HHSC)					
Technology Initiative	Related Agency Objective	Related SSP Strategy	Status	Anticipated Benefit	Innovation Best Practice Benchmarking
reliability.					
<b>Claims Administrator Reprocurement Activities:</b> Reprocurement activities for the Claims Administrator (MMIS)/PCCM contract including vendor drug.	Objective 2-4. Administrative Support.	1-3	Current	Medical Claims will continue to be paid to Medicaid/CHIP Providers.	Benchmarking: Metrics will be compared between prior contracted administrator and new contracted administrator.
<b>2-1-1 Release Improved Search and Reporting:</b> Enhance the 2-1-1 system with new features.	Objective 4-1. Assistance Services	3.1	Current	Provide the customer with improved speed and search capabilities, enhance user reporting capabilities, and provide more user administrative capabilities.	Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI).
<b>HHSC Business Continuity Planning:</b> Establish processes for emergency CIT provisioning. Update prior CIT Disaster Recovery roles and responsibilities. Communicate provisioning plan to the program areas. Evaluate one program area's business Continuity plan. Do a drill. Includes cell	Objective 4-2. Other Support Services.	3.1	Current	Effective communication of Business Continuity Plan and Disaster Recovery Plan roles and responsibilities.	Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These were derived from the use of PM standards including (but not

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phones, telephones, copier/fax machines, computers. Includes cost estimates for various levels of service. Excludes Data Center.					exclusively) such as those of the PMBOK (PMI).
<p><b>TMS (Telecommunications Managed Services) Initiatives</b></p> <p><b>1) Category 3 Refresh, FY 10 - 11:</b> Replace existing telecommunication systems at approximately 75 sites through out the state.</p> <p><b>2) - OES 2 to 1 Trunking:</b> Install additional outbound trunking at Office of Eligibility Services (OES) prioritized sites - doubling (2 to 1) the existing trunking for OES workers.</p>	Objective 4-2. Other Support Services.	1.2	Current	In order to improve performance through increased service flexibility, replace aging equipment with state-of-the-art technology that is scalable to meet changing business requirements, provide a more uniform system architecture, consolidate services for a number of organizations. Saving time and money by allowing the interview process to be done via telephone as opposed to having the client interviews in person. Allows shared telecom resources for non-TWA staff.	Best Practice: Refresh aging telephone systems. Add trunk capacity for anticipated increase in call load Benchmarking: Metrics can be compared which will show the savings in time and money.
<p><b>Data Center Transformation:</b> Facilitate planning and execution of Team for Texas transformation of data center services to their two data centers.</p>	Objective 6-1. Information Technology Projects.	1.1	Current	There will be a coordinated, interruption-free transition to the new data center(s).	Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. These include, but are not limited to, alignment of platforms and architectures to the State of Texas Enterprise

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					Technology Plan and use of ITIL-driven processes from the Data Center Services Policy and Procedures Manual.
<b>ASOIG Enhancements:</b> Add functionality and expand system attributes of the ASOIG application,	Objective 7-1, Integrity and Accountability	4.2	Completed 10/29/2009	This effort will further ensure the proper handling of the investigations of fraud. In addition, the reporting and report simplification will establish greater use of the application and its associated functionality.	The application is applying new technologies and coding practices that are easier to support and maintain. Innovative methods of data extraction are being applied (use of data views) and were implemented to save storage space (a massive amount of data is in the application). Best practices and Governance standards are being applied to ensure the scope and project are in-line with the agency goals. ROI will be reviewed in the future related to the amount of dollars recovered and/or

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					the case specifics such as the time from entry to closure, recovery or case handling. These were derived from the use of PM standards including (but not exclusively) such as those of the PMBOK (PMI).
<b>Enhanced Eligibility Systems (includes TIERS)</b>	Objectives 1-1 Enterprise Oversight and Policy 3-1 Chip Services 5-1 Program Support 6-1 Information Technology Projects	1.1	Current		Innovation – Using rules-based technologies to more efficiently serve clients.
<b>Enterprise Data Warehouse Business Intelligence</b>	Objectives 1-1 Enterprise Oversight and Policy 5-1 Program Support 6-1 Information Technology	1.1	Current	Provide a consolidated view of diverse data sources currently stored in a variety of formats and locations. (Medicaid, CHIP, food stamps and TANF. Detect fraud and abuse. Reduce overall costs to taxpayers, providing the state’s human service needs and priorities in the future, improve delivery of health care services.	Innovation – Using the latest business intelligence industry practices to provide comprehensive data analysis capabilities.

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	projects				
<b>Data Center Services</b>	Objective 6.1 Information Technology Projects	1.1	Current	Replacement of outdated mainframe computer, improved bulk print/ mailing capability; enhanced disaster recovery mechanism.	
<b>State Hospital/State Living Centers Software applications</b>	Objective 6.1 Information Technology Projects	1.1	Planned	To continue progress toward an electronic medical record for patients/clients providing access to all records of persons served from a single access point, reduce paper and provide a seamless delivery of records; to improve and care of residents, improve staff training and productivity.	Innovation – Using increasing trend toward electronic medical records to provide the best in patient care.
<b>Texas Electronic Benefit Transfer (TxEBT) System AIX Transformation Project</b>	Objective 6.1 Information Technology Projects	1.1	Current	To migrate TxEBT to new hardware that is running on UNIX. The project will then move the data center operations from DIR's Network Security and Operations Center for the new Austin Data Center operated by Team for Texas.	