Health and Human Services System Strategic Plan 2015–2019

Volume I

Health and Human Services Commission

Department of Aging and Disability Services

Department of Assistive and Rehabilitative Services

Department of Family and Protective Services

Department of State Health Services

Additional copies are available from:
Texas Health and Human Services Commission
Strategic Decision Support
(512)424-6984
P.O. Box 13247
Austin, Texas 78711-3247

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Health and Human Services System Strategic Plan
2015–2019

Health and Human Services Commission

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Submitted July 7, 2014

Foreword

Five agencies comprise the Health and Human Services (HHS) System:

- 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).

Meeting Multiple Requirements

This Plan consolidates the Strategic Plans for all agencies in the HHS System into one document. Chapters 1 and 2 relate the HHS System efforts to the Governor's Strengthening Our Prosperity: The Statewide Strategic Planning Elements for Texas State Government. Chapter 3 gives an overview of external trends affecting demands for services. Chapter 4 describes interagency planning and coordination efforts. Chapters 5 through 9 contain each agency's Strategic Plan, including external and internal challenges and opportunities. Together, these materials constitute the Coordinated Strategic Plan for Health and Human Services.

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

- **Strategic plan—**required of each state agency, by Texas Government Code, Chapter 2056, STRATEGIC PLANS OF OPERATION;
- **Coordinated Strategic Plan—**required by Texas Government Code, Section 531.022, COORDINATED STRATEGIC PLAN FOR HEALTH AND HUMAN SERVICES; and
- **Historically Underutilized Businesses (HUB) Plan—**required as part of each strategic plan, by Texas Government Code, Section 2161.123, STRATEGIC PLANNING, and presented in Chapter IV, HHS System Ongoing State Planning Requirements and Initiatives.

Fiscal Year Terminology

In this Plan, the term “fiscal year” means the fiscal year for the State of Texas, from September 1 of a year through August 31 of the following year. It is spelled out the first time it is used in each section, and it is abbreviated “FY” through the rest of that section. The exception is when “federal fiscal year” is also used in the same section, in which case “state fiscal year” and “SFY” are used to draw the distinction in time periods.

The term “federal fiscal year” is used to specify the budget period for the federal government, from October 1 of a year through September 30 of the following year. It is spelled out the first time it is used in a section and is abbreviated “FFY” in that section.

Legislative Citations

For brevity, this Strategic Plan uses a short citation for legislative material.

Long Form	**Short Form**
Senate Bill 7, 83rd Legislature, Regular Session, 2013	Senate Bill 7 (83-R)
Senate Bill 7, 82nd Legislature, First Called Session, 2011	Senate Bill 7 (82-1)
2010–2011 General Appropriations Act, S.B. 1, 81st Legislature, Regular Session, 2009 (Article II, Health and Human Services Commission, Rider 59)	HHSC’s Rider 59 of the 2010–2011 General Appropriations Act (81-R)

The abbreviations “H.B.” and “S.B.” are established and used if the bill is cited more than one time in a section.

Terminology for Demographic Groups

The demographic terminology used in most sections of 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” whereas the SDC uses “Black.” “African American,” without a hyphen, is used as a noun, and “African-American,” with a hyphen, indicates that the phrase is an adjective describing the noun that follows. 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.

Headings

The following headings are used in this document.

Heading 1

Heading 2

Heading 3

Heading 4

Heading 5

Heading 6

Certain common headings, such as “Discussion” and “Planned Actions,” may appear at different heading levels in different locations in the document, depending on the organization of the content.

Texas Health and Human Services System Strategic Plan 2015–2019

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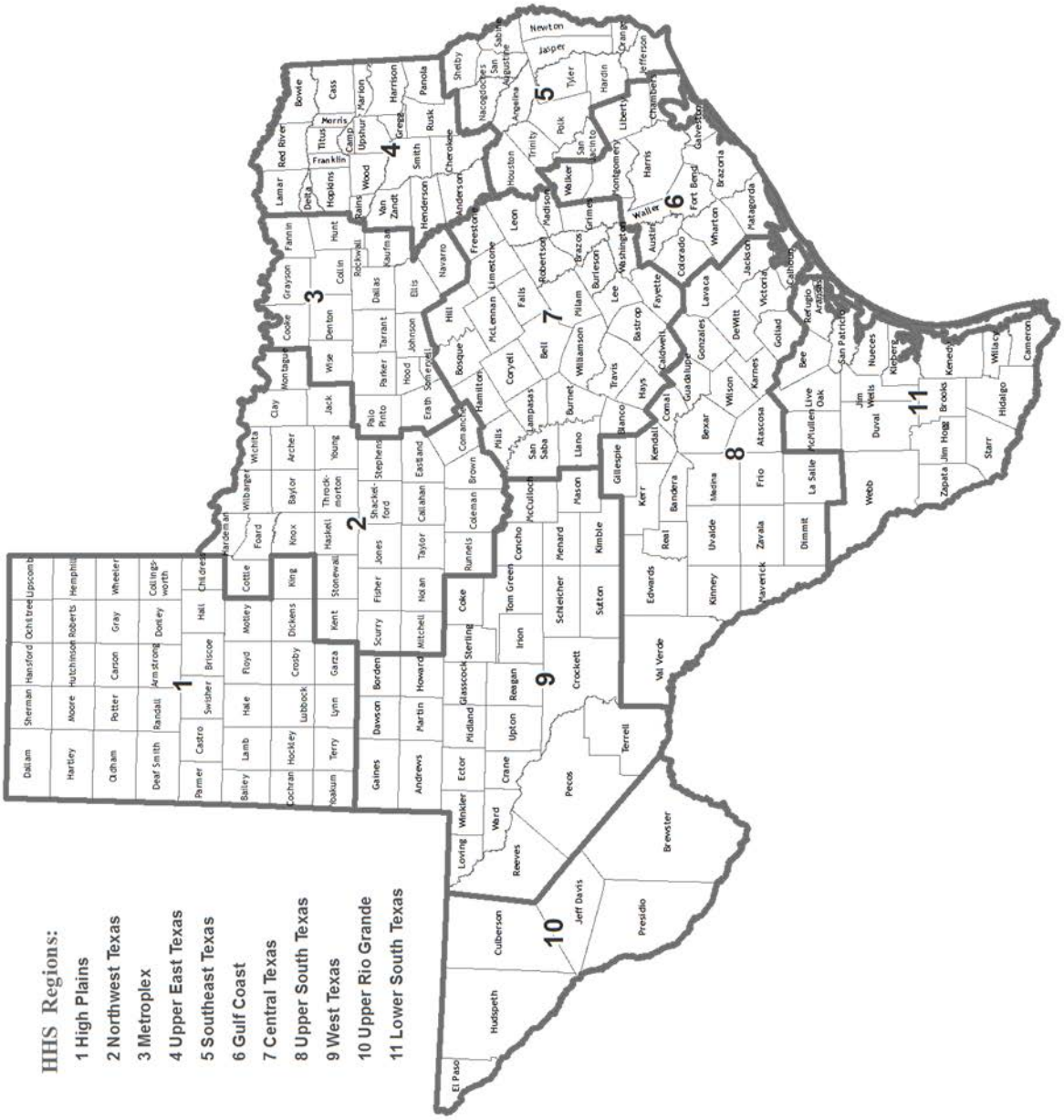

Figure A. Health and Human Services System - Strategic Decision Support.

Chapter 1

Statewide Vision, Mission, and Philosophy

1.1 Introduction

Through the enactment of House Bill (H.B.) 2292 (78-R), the Governor and Legislature directed the Texas health and human services agencies to consolidate twelve agencies into five to streamline organizational structures, eliminate duplicative administrative systems, and to improve the effective and efficient delivery of health and human services to Texans.

H.B. 2292 (78-R) assigned the Health and Human Services Commission (HHSC) responsibility for system policy and oversight, and the operation of several major programs. Under this consolidated structure, all the Health and Human Services (HHS) System agencies have worked together every two years to produce a single strategic plan to address common themes and challenges across the system. This document includes the individual plans for each of the five agencies:

- 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 Governor's Statewide Vision—Strengthening Our Prosperity

Fellow Public Servants:

Since the last round of strategic planning began in March 2012, our nation's economic challenges have persisted, but Texas' commitment to an efficient and limited government has kept us on the pathway to prosperity. Our flourishing economic climate and thriving jobs market continue to receive national attention and are not by accident. Texas has demonstrated the importance of fiscal discipline, setting priorities and demanding accountability and efficiency in state government. We have built and prudently managed important reserves in our state's "Rainy Day Fund," cut taxes on small business, balanced the state budget without raising taxes, protected essential services and prioritized a stable and predictable regulatory climate to help make the Lone Star State the best place to build a business and raise a family.

Over the last several years, families across this state and nation have tightened their belts to live within their means, and Texas followed suit. Unlike people in Washington, D.C., here in Texas we believe government should function no differently than the families and employers it serves. As we begin this next round in our strategic planning process, we must continue to critically examine 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 continue to adhere to the priorities that have made Texas a national economic leader:

- *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.*

I am confident we can address the priorities of our citizens with the limited government principles and responsible governance they demand. I know you share my commitment to ensuring that this state continues to shine as a bright star for

opportunity and prosperity for all Texans. I appreciate your dedication to excellence in public service and look forward to working with all of you as we continue charting a strong course for our great state.

Sincerely,
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.

Aim high . . . we are not here to achieve inconsequential things!

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 of Budget, Planning, and Policy, and the Legislative Budget Board and are 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;*
- *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 health care delivered to clients in multiple state programs.*

Statewide Benchmarks Relevant to HHSC

- Percentage of Texas population enrolled in Medicaid, Children's Health Insurance Program (CHIP), and the Health Insurance Premium Payment programs;
- 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 food stamps;
- Number of Texans using call centers and the Internet to apply for Medicaid, food stamps, and other state services; and
- Number of women served through the Texas Women's Health Program.

Statewide Benchmarks Relevant to DADS

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

Statewide Benchmarks Relevant to DARS

- Percentage of population under age 3 years served by the Early Childhood Intervention Program;
- Percentage of children with autism receiving services from the DARS Autism Program; and
- Percentage of people completing vocational rehabilitation services and remaining employed.

Statewide Benchmarks Relevant to DFPS

- Average daily caseload for Child Protective Services;
- Average daily caseload for Child Care Licensing;
- Average daily caseload for Adult Protective Services;
- Incidence of death due to confirmed abuse or neglect of the elderly, or spouses per 1,000 population;
- Incidence of abuse, neglect, or death of children per 1,000 population;
- Percentage of children in foster care who achieve permanency; and
- Percentage of children in substitute care living with kinship care providers.

Statewide Benchmarks Relevant to DSHS

- 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,
- 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 women served through the Texas Breast and Cervical Cancer Program,
- Number of people who receive mental health crisis services at community mental health centers,
- Number of women served through the Family Planning Program, and
- Number of women served through the Expanded Primary Health Care Program.

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.*

Statewide Benchmarks Relevant to DADS, DFPS, and DSHS

- 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 online.

1.5.3 General Government

Priority Goal

To provide citizens with greater access to government services while reducing service delivery costs and protecting the fiscal resources for current and future taxpayers by:

- *Supporting effective, efficient, and accountable state government operations;*
- *Ensuring the state's bonds attain the highest possible bond rating; and*
- *Conservatively managing the state's debt.*

Statewide Benchmarks Relevant to the HHS System

- Number of state services accessible by Internet

Chapter 2

Health and Human Services System Executive Summary

2.1 Introduction

Five agencies comprise the Health and Human Services (HHS) System:

- 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).

Together, the HHS System agencies support and improve clients' health, safety, and well-being through many services, including physical and behavioral health care, transition to self-sufficiency, food benefits, rehabilitation, help when disaster strikes, and protection from abuse, neglect, or exploitation. In addition, the HHS System agencies have regulatory functions, proactively working toward health and safety in public establishments, such as restaurants, medical facilities, nursing homes, day care centers, and facilities operated by the state or contracted by the state.

To align efforts and focus on outcomes, the agencies share six Strategic Priorities, listed below. In the planning period of 2015–2019, there may be greater demand for services from increasing numbers of individuals and families, as discussed in Chapter 3 and throughout the Plan. Chapter 4 highlights interagency efforts. Chapters 5 through 9 contain each agency's Strategic Plan, including external and internal challenges and opportunities. Chapter 10, to be published with the final plan in July 2014, presents each agency's Goals, Objectives, and Strategies associated with the agency's budget and listed in the General Appropriations Act. The Appendices, also to be published with the final plan in July 2014, will provide in-depth information about the workforce and other topics.

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; and
- 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 and protect the health and well-being of Texans.

- Emphasize health promotion, disease prevention, early intervention, and primary care in a quality-oriented, electronically-enabled, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Improve access to effective services across systems for behavioral health, including prevention, treatment, and recovery services, and integrate physical and behavioral health services.

- Improve access to preventive health care and family planning services for women.
- Improve coordination and accessibility of veterans' health services and employment opportunities, as appropriate, within the health and human services system.
- Ensure all programs and initiatives recognize and address health disparities and disproportionality to improve outcomes.
- Continue to improve disaster prevention, preparedness, and response.
- Continue improving the availability of timely and accurate information to support data-driven decision-making, and invest in systems to leverage the state's health information exchange network where appropriate.

2.4.2 Create opportunities that lead to increased self-sufficiency and independence.

- Ensure policies and services encourage responsibility, promote self-service options, and improve access to competitive employment for all Texans.
- Partner with people with disabilities, including people with behavioral health issues, in overcoming barriers to full participation in the community and the workforce.
- Assist older Texans and those with disabilities to gain, maintain, and enhance their ability to live independently.
- Ensure children who have intellectual disabilities or developmental delays have the same opportunities as other Texans to pursue independent and productive lives.
- Support children and youth in health and human services programs to ensure their successful transition into adulthood.

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

- Ensure the safety and well-being of Texans in facilities regulated by, operated by, or provided via contract with the state, as well as those served in their homes.
- Improve detection of potential risk of harm to vulnerable children and adults in the residential settings regulated by, operated by, or provided via contract with the state and ensure that appropriate services are offered and provided when abuse, neglect, or exploitation is suspected or occurs.

- Create a regulatory environment that fosters the health, safety, and opportunities of Texans while ensuring a pro-business approach that supports accountability and innovation.
- Work with law enforcement to support prosecutions of people suspected of criminal abuse, neglect, or exploitation.

2.4.4 Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.
- Work closely with faith- and community-based organizations to assist people in applying for nutrition, medical, monetary, and other assistance.
- Explore opportunities to address co-occurring issues across disciplines and consider integrated service and treatment alternatives.
- Continue to enhance interagency partnerships, coordination, and information-sharing in addressing clients' complex needs.
- Further expand partnerships with institutions of higher education to foster collaborative efforts and workforce development.

2.4.5 Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.
- Encourage communication, teamwork, and innovation.
- Recruit, retain, and motivate the health and human services workforce by investing in employees with exemplary performance and by providing opportunities for professional development and advancement.
- Provide an accessible, secure, and safe work environment, including training for employees to respond appropriately to difficult or dangerous situations, whether in the office or in the field.

- Use technology and other means to maximize work efficiency and eliminate costly maintenance and repair on unneeded or underutilized office space.
- Ensure the security of agency data and privacy of client data.

2.4.6 Ensure the integrity of health and human service providers.

- Optimize the prevention, detection, and correction of fraud, waste, and abuse, focusing on high-risk areas.
- Continue to coordinate with managed care special investigative units to optimize the prevention, detection, and correction of fraud, waste, and abuse.

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) System agencies operate. Projected changes in the size, composition, and geographical distribution of the population will likely have a strong impact on agencies and programs. Particular demographic trends to watch include the aging of the population, increased longevity, and more race/ethnic diversity.

In the coming years, the age structure of the population, both in Texas and nationally, is projected to change dramatically, as the percent share of the population of people ages 65 and older increases. Additionally, with continued advances in medicine, those who reach age 65 will have a greater likelihood of living past age 85. Thus, the population of people ages 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.

The discussion below addresses the key demographic and economic trends that could impact agencies and programs in the HHS System in the years ahead. The implications of these trends and impacts are discussed later in the agency chapters, Chapters 5–9.

The demographic terminology used in this Strategic 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” whereas the SDC uses “Black.” “African American,” without a hyphen, is used as a noun, and “African-American,” with a hyphen, indicates that the phrase is an adjective describing the noun that follows.

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

Since becoming a state in 1845, Texas has consistently experienced higher population growth compared to most of the other states. This rapid growth has accelerated during the last 30 years and continues to be very strong today. Texas' population is projected to continue growing during the 2015–2019 planning period.[1] The projected population of 27.7 million by 2015 represents an increase of 2.6 million over the 2010 Census count of 25.1 million. The SDC projects that between 2015 and 2019 the state's total population will grow by another 2.3 million, by 8 percent. This growth rate is more than twice as high as the projected growth rate for the United States (U.S.) as a whole over the same period.[2] It is projected that the state's total population will reach 30 million in 2019. This growth pattern is projected to hold over the long term future also. The SDC projected that the state's population will reach 45.4 million in 2040, for a population growth rate of 64 percent between 2015 and 2040.

According to analyses conducted by the U.S. Census Bureau regarding population growth trends in Texas during the 2010–2013 period, natural increase, which is population growth resulting from the excess number of births over the number of deaths, accounted for 53 percent of the total population growth in the state. The rest of the growth, 47 percent, was due to positive net migration, both domestic and international in origin, into the state. The Bureau estimates that during 2010–2013 international migration accounted for 34 percent of all the migration into Texas.

[1] The SDC is the source for Texas population projections data cited in this Strategic 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. The population projections for Texas cited throughout this Plan are derived from the 2000-2010 Migration Growth Scenario, which uses the 2010 Census Count as the base for the figures used in population projections.
[2] U.S. Census Bureau. 2012 National Population Projections, 2015–2060, Middle Series.

Aging of the Population

The SDC projects a dramatic shift in the age structure of the population in the coming decades. This Strategic Plan focuses on trends for the years 2015–2019, but it is also useful to discuss some of the projected long-term trends. The number of people ages 65 and older is projected to grow from 3.2 million in 2015 to 7.5 million in 2040. This group's percentage of the total population is projected to increase from 12 percent in 2015 to 17 percent by 2040. Similarly, the percentage of people ages 85 and older is also projected to increase, doubling from 1 percent in 2015 to 2 percent in 2040.

The median age for the Texas population, which was close to age 34 in 2010, is projected to increase to age 37 in the year 2040.[3] The median age is projected to increase for all major race/ethnic groups.

Although the population of people ages 65 and older is projected to grow across all race/ethnic groups, the growth will be more dramatic in the non-Anglo groups. Between 2015 and 2040, the following growth rates are projected in the population of people age 65 or older according to race/ethnicity:

- Anglos—59 percent,
- African Americans—192 percent,
- Hispanics—282 percent, and
- All other groups (combined)—359 percent.

Figure 3.1 compares the projected size of the population of people ages 65 and older in 2015 and 2040 according to race/ethnicity. The population of people ages 65 and older Anglos is projected to grow from 2.1 million to 3.3 million; the African-American population is projected to grow from 285,000 to 830,000; and the Hispanic population is projected to grow from 722,000 to 2.8 million. For all other groups combined, the population is projected to grow from 137,000 to 630,000.

[3] Ibid.

Figure 3.1
Texas Population Ages 65 and Older by Race/Ethnicity,
Years 2015 and 2040

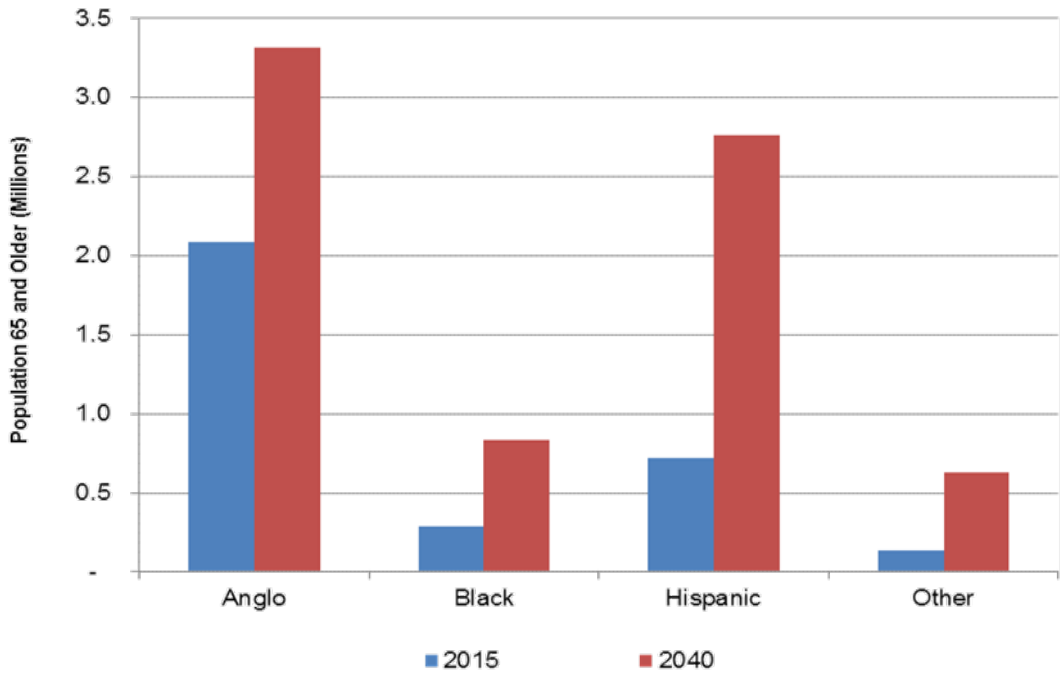

Figure 3.1: Texas State Data Center; Health and Human Services System - Strategic Decision Support, 2014.

Prevalence of Disability

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

The American Community Survey (ACS) for Texas, conducted by the U.S. Census Bureau, indicates that in 2012 there were approximately 2.9 million Texans with a disability. This number represents 11.6 percent of the total population. Among

adults ages 18 through 64, the ACS reports that 10 percent had a disability in 2012. Among adults ages 65 and older, the ACS reports that 39.1 percent had 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 a Disability in 2012 by Age Group

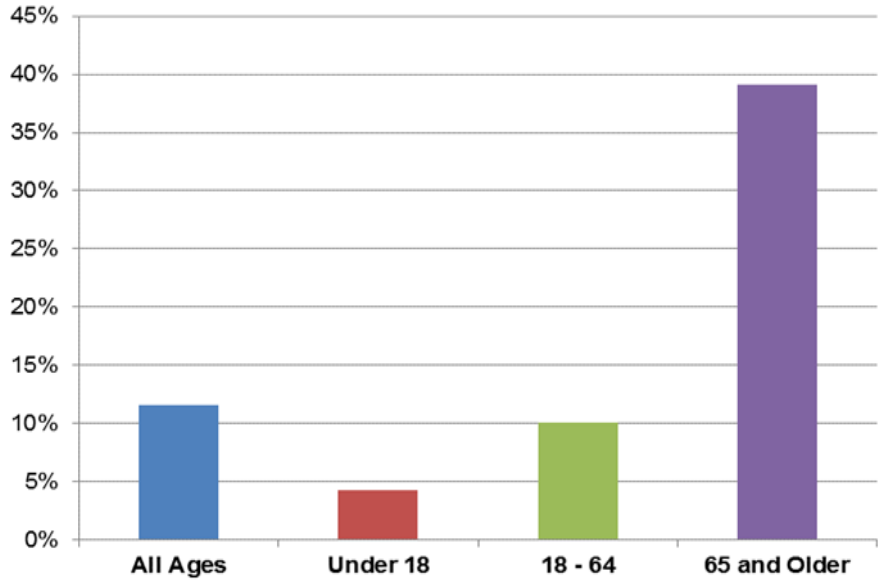

Figure 3.2: U.S. Census Bureau, 2012 American Community Survey for Texas; Health and Human Services System - Strategic Decision Support, 2014.

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 2015, Anglos are projected to comprise 42 percent of the population, while Hispanics are projected to comprise 40 percent. African Americans are projected to comprise 11 percent, and all the other groups, combined, are projected to account for the remaining 7 percent.

The SDC projects the following growth trends between 2015 and 2019.

- The Anglo population is projected to grow from 11.7 to 11.9 million, for a growth rate 2 percent.
- The African-American population is projected to grow from 3.2 to 3.4 million, for a growth rate of 8 percent.
- The Hispanic population is projected to grow from 11.1 to 12.6 million, for a growth rate of 14 percent.
- The population of all other population groups (combined) is projected to grow from 1.8 to 2.1 million, for a growth rate of 19 percent.

The higher growth rates 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 health issues and diagnoses tend to be more prevalent in some racial-ethnic groups compared to others—for example, Type II diabetes among Hispanics.[4] The implications of some of these dynamics are discussed in more detail later in this chapter and in Chapter 9, the Department of State Health Services Strategic Plan.

Rural Population Concerns

The majority of the Texas population resides in urban and suburban counties that are part of a metropolitan area. Based on the U.S. Office of Management and Budget classification, as of February 2013, 82 Texas counties are classified as metropolitan, while 172 are classified as non-metropolitan.[5] By definition, the 172 non-metropolitan counties are more rural in character compared to the 82 metropolitan counties.

The SDC projects that in 2015 approximately 3.1 million, or 11 percent of the total population of 27.7 million, will reside in non-metropolitan counties, while 24.6 million, or 89 percent of the total population, are projected to reside in metropolitan counties. According to the SDC, between 2015 and 2019 non-metropolitan counties will add approximately 123,000 new residents, while metropolitan counties will add another 2.2 million.

Although the combined number of residents across all non-metropolitan counties account for a relatively small fraction of the state's total population, the total

[4] Texas Behavioral Risk Factor Survey (http://www.dshs.state.tx.us/chs/brfss/).
[5] 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.

population for those counties, when combined, exceeds the total population of many states.

Residents of counties or areas that are more rural and isolated in character tend to experience particular circumstances with implications 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 services,
- Limited job opportunities and other incentives for youth to stay in the community,
- Limited transportation options,
- Limited economic development, and
- Limited fiscal resources.

3.1.2 Economic Forecast

Texas has experienced improved economic conditions during the last three years. According to the Texas Workforce Commission (TWC), the seasonally adjusted unemployment rate in the state was 5.7 percent in January 2014, significantly lower than the recorded rate of 8.1 percent for January 2011. The number of employed persons in January 2014 was 12.1 million. There were 734,000 more employed persons in January 2014 than in January 2011.

Improved labor market conditions and the expansion the state's economy have had a positive impact on state revenue collections. The Texas Comptroller of Public Accounts reports that state tax collections during state fiscal year 2013 increased by $7 billion or 17 percent compared to state fiscal year 2012. An important positive sign is that the growth rate in state tax collections for 2013 exceeded the annual population and inflation growth rates, combined.

Independent analyses also confirm that the state's economy has recently been expanding at a healthy pace. Texas' gross state product, an indicator of the size of the state's economy, expanded at an annual rate, adjusted for inflation, of close to five percent during the 2010–2013 period.[6] As of March 2014, the state's economy is projected to grow by close to four percent in 2014 on an inflation-adjusted basis.[7]

In spite of these encouraging signs, there is still room for additional improvement. In terms of labor market conditions, the TWC reports that the seasonally adjusted

[6] IHS Global Insight, March 2014.
[7] IHS Global Insight, March 2014.

statewide rate of unemployment of 5.7 percent for January 2014 is more than a full percentage point higher than the pre-recession rate of 4.4 percent recorded for January 2008. Furthermore, analysis of data collected by the United States (U.S.) Census Bureau's American Community Survey for Texas indicate that the median family income in Texas was 4 to 5 percent lower in 2012 than in 2008 on an inflation-adjusted basis, depending on the index that is used to measure inflation (standard versus chained consumer price index).

Some of these factors might help explain why the percent of Texans participating in certain programs, such as the Supplemental Nutrition Assistance Program, Medicaid, and the Children's Health Insurance Program, was higher in January 2014 than in January 2008. In 2014, Texas continues to confront important socioeconomic and health care access challenges, which include a higher than average rate of poverty and higher than average percentage of people without health insurance as compared to the nation as a whole.

Poverty

Individuals and families living in poverty often rely on health and human services, so it is useful to review trends for this population and to assess potential impacts on the Texas Health and Human Services System.

The U.S. Department of Health and Human Services defines the annual federal poverty level (FPL) for family incomes for 2014 for certain family sizes as follows:

- $23,850 or less for a family of four,
- $19,790 or less for a family of three,
- $15,730 or less for a family of two, and
- $11,670 or less for individuals.

According to the U.S. Census Bureau’s March 2013 Current Population Survey (CPS) for Texas, in 2012 an estimated 4.1 million Texans, or 17 percent of the state's population, lived in households/families with annual incomes below the FPL.[8] Nationally, 15 percent of the population lived in households/families with income below the FPL in 2012.

Research conducted by the Texas Health and Human Services Commission staff indicates that if the 2012 poverty rate of 17 percent were to hold during the foreseeable future, the number of Texans in households/families with incomes below the poverty level would reach approximately 4.7 million in 2015 and 5.1 million in 2019.

[8] U.S. Census Bureau, March 2013 Current Population Survey (CPS) for Texas.

Poverty and Race/Ethnicity

The percent of the population below the FPL varies by race and ethnicity. According to the March 2013 CPS, 8 percent of Anglos, 22 percent of African Americans, 26 percent of Hispanics, and 11 percent of persons in all other groups lived in households/families with incomes below the FPL in 2012.

The percent of the child population, younger than age 18, living below the FPL also varies by race/ethnicity, with the percentage being higher among non-Anglo children. In 2012, 10 percent of Anglo children were in families with annual incomes below the poverty level, compared to 31 percent of African-American children, 35 percent of Hispanic children, and 13 percent of children in other groups.

3.1.3 Health Trends

Health Insurance Coverage

The United States (U.S.) Census Bureau's March 2013 Current Population Survey (CPS) gathered health insurance coverage information for 2012, reporting new information.

- There were 6.4 million Texas residents without health insurance, counting both citizens and non-citizens; this number represented close to 25 percent of the Texas population.
- Of the 6.4 million uninsured, most were younger than age 65 (6.3 million), and 1.1 million of the approximately 7 million children younger than age 18 in the state were uninsured.
- More than 90 percent of the population of people ages 65 and older was covered by Medicare.
- There was disproportionate representation in the ranks of the uninsured on the basis of race/ethnicity.
    - Anglos represented 42 percent of the total population, but were 25 percent of the uninsured.
    - Hispanics represented 41 percent of the total population, but were 62 percent of the uninsured.
    - African Americans represented 11 percent of the total population, but were 9 percent of the uninsured.

According to an analysis by the Health and Human Services Commission of March 2013 CPS data for 2012, some of the key characteristics of the uninsured population in Texas include the following:

- Sixty-one percent come from households/families with income below 200 percent of the federal poverty line.

- Seventy-eight percent are U.S. citizens.
- Fifty-three percent—3.4 of 6.4 million uninsured—are adults 18 and older employed at a job.
- Among those ages 18 and older, 50 percent of those without a high school diploma are uninsured, compared to 11 percent among those with a college degree.
- With the share of people who do not have insurance at 42 percent of the population, the 18–24 age cohort has the highest rate of uninsured of any age cohort. The 25–34 age cohort has the second highest rate of uninsured, at 36 percent in 2012.

Less Private Insurance, Increased Reliance On Medicaid/CHIP

In recent years, the percent of the population with private health insurance has decreased, both in Texas and in the U.S. as a whole. In Texas, the percent of the population with private insurance was 66 percent in 2000, compared to 55 percent in 2012. In the U.S., the percent of the total population with private insurance was 74 percent in 2000 but 64 percent in 2012.

During that same period, the percent of the population participating in Medicaid or the Children's Health Insurance Program (CHIP) increased both in Texas and in the U.S. In Texas, the percent of the total population participating in Medicaid/CHIP increased from 8 percent in 2000 to 14 percent in 2012, while in the U.S. the percent of the total population participating increased from 10 percent in 2000 to 16 percent in 2012.

Among children younger than age 18, the increase in the percentage that participates in Medicaid/CHIP has been more dramatic. According to the U.S. Census Bureau's March CPS, between 2000 and 2012 the percent of Texas children younger than age 18 participating in Medicaid increased from 17 percent in 2000 to 37 percent in 2012. In the U.S., the increase was from 21 percent in 2000 to 36 percent in 2012.

According to the most recent data available from the March 2013 CPS for 2012, there were variations according to age group in the percent participating in private insurance versus Medicaid/CHIP at any point during the course of the year.

- Among all Texans, 55 percent had private insurance, and 14 percent had Medicaid or CHIP.
- Among Texans younger than age 65, 56 percent had private insurance, and 15 percent had Medicaid or CHIP.
    - Among Texans younger than age 18, 50 percent had private insurance, and 37 percent had Medicaid or CHIP.
    - Among Texans ages 18 to 64, 59 percent had private insurance, and 6 percent had Medicaid or CHIP.

Impact of Natural Disasters and Infectious Diseases

In recent years, the Department of State Health Services (DSHS) has engaged in a variety of responses to public health emergencies and disasters. These responses range from severe storms and hurricanes to ongoing control and prevention activities related to emerging and re-emerging infectious diseases.

There is a trend toward more frequent and more diverse public health emergencies and disasters. From 1955 to 2005, every federally declared major disaster in Texas resulted from hurricanes, severe storms (tornados, flooding, etc.), or winter storms. From 2006 to 2013, there were 12 federally declared major disasters in Texas and one third was not specifically weather related. This includes three wildfire declarations and a large industrial explosion. In addition, there have been recent responses to major infectious disease outbreaks. The DSHS response and incident management systems are being used more frequently for complex regional emergencies, such as an investigation of mercury-contaminated face cream in the Lower Rio Grande Valley, a severe tuberculosis outbreak in health service region 2/3, infection and deaths associated with specialty compounding, a ventilator shortage in Eagle Pass, and a statewide injectable saline shortage.

West Fertilizer Company Explosion

In April 2013, an ammonium nitrate explosion occurred at the West Fertilizer Company storage and distribution facility in West, Texas, 18 miles north of Waco. The explosion occurred while emergency services personnel were responding to a fire at the facility. DSHS activated the State Medical Operations Center (SMOC) to provide resources and behavioral health support to the area and worked with local entities to meet disaster response needs given the magnitude of the event. More than 200 people were injured, and 15 died, including 12 first responders.

DSHS-funded hospital preparedness and public health emergency preparedness resources were activated immediately following the explosion. Local patient surge plans that had been developed through support from DSHS programs successfully assured immediate bed availability during the initial influx of injured persons. The DSHS regional office supported the local public health and mental health authorities and took a leadership role in coordinating the disaster behavioral health response.

West Nile Virus Outbreak

The 2012 West Nile Virus (WNV) season in Texas was the most severe on record. During the spring and early summer of 2012, DSHS, along with local health department partners, performed routine surveillance and epidemiologic activities related to WNV. As the number of confirmed human cases began to rise, DSHS activated the SMOC and its public health emergency preparedness and response functions to coordinate the state's response. The impact included 1,868 WNV

human cases, 844 WNV neuroinvasive disease cases (most severe form of the disease), and 89 deaths.

DSHS provided leadership throughout the response by maintaining situational awareness, compiling case counts, and coordinating key information with local and federal partners. Other activities included conducting laboratory testing, coordinating with the Centers for Disease Control and Prevention teams to assist in outbreak analysis, providing geographic information system mapping of cases and incidence rates, developing and disseminating public outreach and education, and activating vector control contracts and providing other support for ground and aerial spraying.

Pertussis Outbreak

Pertussis in Texas has generally occurred in the standard three- to five-year peak cycle. The current statewide upswing started in 2012 and continued into 2013. As of March 7, 2014, 3,977 cases from 148 counties had been reported for 2013, making this the highest number of annual cases reported in Texas since 1959. Children younger than age one have the highest rate of pertussis, and five deaths were reported in 2013, all in infants too young to be vaccinated.

DSHS has activated a multi-faceted response to the outbreak. Since 2012, current, relevant data and information have been posted to the DSHS Infectious Disease Control Unit website on a monthly basis. In August 2013, DSHS developed an action plan and distributed a Pertussis Communication Toolkit to local and regional health departments. In September 2013, DSHS issued a press release and a health alert to medical associations and local and regional health departments.

Infants are optimally protected when pregnant women get the pertussis vaccine during pregnancy, preferably between 27 and 36 weeks of pregnancy. This protects the baby before the baby's vaccination series starts at two months of age and prevents the mother from getting pertussis and infecting the young infant. In an effort to increase awareness about this recommendation, DSHS implemented the Prevent Pertussis public awareness campaign. As part of this campaign, in November 2013, DSHS sent a letter and patient education materials with information about the vaccine to providers across the state, and released television and radio ads targeting pregnant women.

Healthcare-Associated Infections

Healthcare-associated infections (HAIs) have emerged as a significant cause of morbidity and mortality nationally and in Texas. In 2000, the Institute of Medicine estimated 1.7 to 2.0 million people acquired HAIs annually in the U.S., and as many as 98,000 patients died due to preventable medical harm. In an effort to reduce HAIs, the Texas Legislature mandated HAI reporting in 2007. HAIs selected for

reporting in general hospitals and ambulatory surgery centers, other than pediatric and adolescent hospitals, are:

- Colon surgeries,
- Hip arthroplasties,
- Knee arthroplasties,
- Abdominal hysterectomies,
- Vaginal hysterectomies,
- Coronary artery bypass grafts, and
- Vascular procedures.

Pediatric and adolescent hospitals are required to report:

- Cardiac procedures, excluding thoracic cardiac procedures;
- Ventricular shunt procedures; and
- Spinal surgeries with instrumentation.

General hospitals must report laboratory confirmed blood stream infections from a central line when occurring in special care settings.

DSHS has worked steadily to implement HAI reporting and to increase health care facility transparency and accountability. The initial phase of the Texas Health Care Safety Network, a secure electronic interface for HAI reporting, was completed in 2011. In 2012, 320 general hospitals and ambulatory surgical centers reported HAIs. In 2013, DSHS implemented reporting of infections associated with all ten surgeries as well as central line-associated blood stream infections. The public can view facility level infection rates for each of these events or procedures, including 18 months of data, on the public website at www.haitexas.org.

Health Risk Factors

In 2011, chronic diseases accounted 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 ten leading causes of death in Texas in 2011.

Table 3.1
Leading Causes of Texas Deaths, 2011[9]

Ranking	Disease	Percentage
1	Heart Diseases	22.6%
2	Cancer	22.1%
3	Accidents	5.5%
4	Stroke-Related	5.4%
4	Lung Diseases	5.4%
6	Alzheimer's Disease	3.2%
7	Diabetes-Related	3.0%
8	Blood Infections	2.0%
9	Kidney Diseases	2.0%
10	Liver Diseases	1.8%
All Other Causes		26.8%
Total Deaths in 2011		**100.0%**

Table 3.1: Department of State Health Services, 2013.

Five of the top six leading causes of death in Texas in 2011 have several risk factors in common. Cardiovascular disease includes heart disease, stroke, and congestive heart failure. The risk factors for cardiovascular disease include hypertension, tobacco use, high cholesterol levels, physical inactivity, poor nutrition, obesity, and environmental air quality factors, such as exposure to particulate air pollution and second-hand tobacco smoke. 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

[9] DSHS, "Vital Statistics Annual Report: Leading Causes of Death in Texas - 2011." (http://www.dshs.state.tx.us/chs/vstat/vs11/t16.shtm).

amputations, and blindness. Risk factors for diabetes include poor nutrition, physical inactivity, and obesity.

Understanding certain 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 understand the health status of populations and to inform policymaking. These risk factors include:

- Physical inactivity,
- Obesity,
- Tobacco use,
- Substance use,
- Risky sexual behavior,
- Mental illness,
- Injuries and violence,
- Lack of immunizations,
- Environmental dangers, and
- Lack of access to health care.

Mental Health

Mental illness is a leading cause of disability in the U.S., Canada, and Western Europe. Two large national surveys conducted in the 1980s and 1990s serve as the basis for prevalence estimates for the adult population.[10] It is estimated that 19 percent of the adult U.S. population has a mental disorder during the course of a year. In Texas, the 2013 estimated number of adults with serious and persistent mental illness was 499,389. Approximately 20 percent of children and adolescents have some type of mental disorder. 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.[11] In 2013, the estimated number of children with SED in Texas was 175,137.

Behavioral Risk Factors

The leading causes of death can be linked to one or more significant behavioral risk factors. Three risk behaviors that are major contributors to cardiovascular disease and cancer include tobacco use, poor nutrition, and physical inactivity. The Texas Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS) take an in-depth look at behavioral risk factor prevalence in Texas

[10] U.S. Department of Health and Human Services. "Mental Health: A Report of the Surgeon General," 1999. (http://www.surgeongeneral.gov/library/mentalhealth/home.html)
[11] Ibid.

and are important tools for decision-making throughout DSHS and the public health community.[12]

Substance Use

Substance abuse is another underlying factor in a wide range of health problems.

Certain statistics characterize alcohol abuse or use in Texas.

- In 2013, the economic impact of alcohol abuse was estimated to be $24.8 billion, which includes health care expenditures, lost productivity, motor vehicle accidents, crime, and other costs.[13]
- Of the 3,938 motor vehicle fatalities in 2012, 1,296 (38 percent) were alcohol-related.[14]
- Alcohol continues to be the most widely used controlled substance among secondary school students. In 2012, 58 percent of high school students reported they had used alcohol, while 25 percent reported past-month alcohol use.[15]

Drug use is costly to the individual, the family, and the state.

- In 2013, the economic impact of illegal drug use was roughly estimated to be $14.1 billion.[16]
- Approximately 41 percent of secondary school students reported that they were not drug-free from all substances, including alcohol, during the 2012 school year.
- In fiscal year 2013, approximately 11 percent of all DSHS-funded substance abuse treatment clients participated in a co-occurring psychiatric and substance use disorders program.[17]

Tobacco Use

Tobacco use is the single largest cause of preventable, premature death and disease in Texas. Tobacco use is a primary contributor to lung disease, heart disease, and diseases of the mouth, breast, pharynx, esophagus, pancreas, kidney, bladder, and uterine cervix. Tobacco products are associated with the deaths of more than 400,000 people in the U.S. every year. In Texas, 24,200 adults die annually from smoking-related causes. Additionally, for every person who dies from a tobacco-related cause, an additional 20 suffer from tobacco-related diseases.

[12] DSHS, BRFSS. (http://www.dshs.state.tx.us/chs/brfss/default.shtm).
[13] Mental Health and Substance Abuse Decision Support Update to the Economic Cost of Alcohol and Drug Abuse, 2013.
[14] National Highway Traffic Safety Administration's Fatality Analysis Reporting System. (http://www-fars.nhtsa.dot.gov/Main/index.aspx)
[15] DSHS, "2012 Texas School Survey of Substance Abuse among Students in Grades 7-12."
[16] Mental Health and Substance Abuse Decision Support Update to the Economic Cost of Alcohol and Drug Abuse, 2013.
[17] DSHS, Clinical Management for Behavioral Health Services Data.

Tobacco use and its related health consequences take a high toll on lower-income and less-educated populations who disproportionately use tobacco products and who have less access to health care due to a lack of insurance. According to the findings from the 2012 Texas BRFSS, individuals with a high school education or less have a 23.4 percent prevalence for smoking and a 45.1 percent prevalence for not having health insurance. This study found that those who make less than $25,000 per year have a 24.1 percent prevalence rate for smoking and 55 percent prevalence for lacking health insurance. This compares to a statewide average of an 18.2 percent prevalence for smoking and a 30.6 percent prevalence for lacking health insurance.

In addition to causing disparate harm to individuals with a lower socio-economic status, tobacco takes a profound toll on persons who also are addicted to alcohol and/or illicit drugs, and those who experience mental illness. According to the National Association of State Mental Health Program Directors, 75 percent of individuals with either addictions or mental illness smoke cigarettes, compared to 22 percent of the general population. Additionally, nearly half of all cigarettes consumed in the U.S. are by individuals with a psychiatric disorder. On average, persons with serious mental illness die 25 years younger than the general population—largely from conditions caused or worsened by smoking.

Nutrition and Physical Activity

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

- The prevalence rate of adults who are either overweight or obese is rising in Texas. In 2012, 65.1 percent of Texas adults were overweight or obese.[18]
- In 2012, 29.2 percent of adult Texans were obese, compared to 27.7 percent nationwide.
- In 2013, 15.7 percent of high school students were obese (at or above the 95th percentile for body mass index, by age and sex).
- Males were more likely than females to be obese (19.4 percent vs. 11.8 percent).
- Hispanic students were more likely than Anglos to be obese (19.0 percent vs. 12.1 percent).

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

- In Texas, 27.2 percent of adults reported no leisure-time physical activity in the past month, compared to 23.9 percent of adults nationwide in 2012.

[18] DSHS, Center for Health Statistics, 2012 Texas Behavioral Risk Factors Surveillance System.

- Hispanics and African Americans in Texas had higher rates of no leisure-time physical activity, 35.3 percent and 28.4 percent respectively, compared to 21.8 percent of Anglos.
- In 2011, over one-half (51.8 percent) of adult Texans had insufficient physical activity according to the 2008 Physical Guidelines.
- According to the 2013 Texas YRBS, 32.9 percent of Texas adolescents in grades 9-12 watched television for three or more hours per day on an average school day.
- African Americans had the highest rate of three or more hours of television time at 49.1 percent, followed by Hispanics at 35.2 percent, and Anglos at 25.5 percent.
- In 2013, more than one out of three Texas high school students (38.0 percent) played video games or computer games, or used a computer that was not for school work for three or more hours per day on an average day.

3.2 Recent State and Federal Policy Direction

This discussion highlights the most significant recent policy direction for the Texas Health and Human Services System as a whole. More agency-specific legislation passed by the 82nd Legislature is referenced in each agency's Strategic Plan, Chapters 5 through 9.

3.2.1 Direction to Contain Medicaid Cost Growth

As Medicaid spending continues to grow, state policy makers have directed the Health and Human Services Commission (HHSC) to pursue multiple efforts to contain Medicaid spending. HHSC's Rider 51 in the 2014–2015 General Appropriations Act (83-R), reduces HHSC's appropriation by $400 million in general revenue based on development of new Medicaid cost containment initiatives, such as implementing payment reform and quality-based payments, increased efficiencies in the vendor drug program, and strengthening prior authorization requirements.

While recent efforts to contain Medicaid costs have produced positive results, 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. Medicaid cost containment efforts are expected to continue to be emphasized in the next biennium.

3.2.2 Expansion of Managed Care

Senate Bill (S.B.) 7 (83-R) requires the Health and Human Services Commission and the Department of Aging and Disability Services to jointly design and implement an acute care services and long-term services and supports system for individuals with intellectual and developmental disabilities through managed care.

S.B. 7 (83-R) included several changes to Medicaid managed care, such as:

- Expanding STAR+PLUS to Medicaid Rural Service Areas,
- Including nursing facilities, and
- Integrating acute care for adults with intellectual and developmental disabilities.

Implementation began in September 2013, and the full redesign will roll out gradually over the next six years through 2020.

S.B. 58 (83-R) requires integration of Medicaid behavioral health services through existing Medicaid managed care entities, except in the NorthSTAR service area, where such services are already integrated.

3.2.3 Prevention of Fraud, Waste, and Abuse

Senate Bill 8 (83-R) allows Texas to take a more proactive approach to prevent Medicaid fraud, and it transitions the non-emergency medical transportation program to a managed care delivery model. The bill strengthens administrative controls of certain programs by:

- Establishing a data analysis unit within the Medicaid/CHIP Division;
- Setting limits on marketing activities by providers;
- Directing a review and study of prior authorization processes, with a report due by December 31, 2014; and
- Strengthening ambulance licensing criteria.

The bill also mandates delivery of Medical Transportation Program services through a managed care model by September 1, 2014.

3.2.4 Federal Program Reauthorizations

Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program, requires federal reauthorization every five years. The

program was reauthorized in January 2014 through House Resolution 2642, the Agriculture Act of 2014, also known as the Farm Bill. Overall, the Act produces a savings of $23 billion over the next decade through changes to agricultural, food safety, conservation, and nutrition programs. The bill cuts approximately $8 billion from SNAP in ten years and reauthorizes appropriations for SNAP and related programs through federal fiscal year 2018.

The farm bill made several changes to SNAP, including:

- Requiring the Secretary of Agriculture to conduct demonstration projects to authorize redemption of SNAP benefits online and with mobile technologies;
- Making households with lottery winners ineligible for SNAP;
- Barring individuals convicted of specified federal crimes (including murder, rape, certain crimes against children) and similar state offenses from receiving SNAP;
- Requiring states to use an electronic immigration status verification system to verify applicants' immigration status;
- Requiring states to use performance bonus payments only for technology, improvements in administration and distribution, and actions to prevent fraud, waste, and abuse;
- Requiring states to submit an annual report to the United States Department of Agriculture showing that the state is verifying that its SNAP recipients are not receiving benefits in more than one state, that no benefits are being paid to deceased individuals, and that no benefits are being paid to previously disqualified individuals; and
- Directing the Secretary of Agriculture to establish a pilot program in up to ten states to develop and test methods, including operating work programs that engage able-bodied adults in work and job training requirements, similar to those for the Temporary Assistance for Needy Families program, for employment and training programs and services.

Temporary Assistance for Needy Families

The Temporary Assistance for Needy Families (TANF) program requires federal reauthorization every five years. The program was scheduled for reauthorization in 2010, but has been continued until September 30, 2014 through periodic short-term extensions. At this time, Congress has neither filed a bill to reauthorize TANF nor identified a legislative vehicle to extend TANF on a short-term basis.

The President's federal fiscal year (FFY) 2015 budget does not provide a full TANF reauthorization proposal, but it specifies that a reauthorization proposal should include performance indicators to drive program improvement. The budget proposal does include a new proposal to repurpose funding currently in the budget's baseline for the TANF Contingency Fund ($612 million in FFY 2015) for other purposes. The TANF Contingency Fund still requires an extension for FFY 2015. Of the $612 million, $10 million would be for technical assistance, research, and evaluation, and

$602 million would be for a Pathways to Jobs initiative. This initiative would be part of TANF and support work opportunities through subsidized employment for low-income parents and youth. Unlike in previous years, the President's budget does not include a proposal to fund TANF supplemental grants, which give increased funding to about a third of the states with historically low grants per low-income person and/or fast-growing populations.

Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) was reauthorized for five years through the Children's Health Insurance Program Reauthorization Act of 2009. In March 2010, the President signed the Patient Protection and Affordable Care Act, and among the many provisions, the law extended the authorization of the CHIP program for an additional two years, through September 30, 2015. The law requires states to maintain current income eligibility levels for CHIP through September 30, 2019. States are prohibited from implementing eligibility standards, methodologies, or procedures that are more restrictive than those in place as of March 23, 2010, with the exception of waiting lists for enrolling children in the program. CHIP will require full federal reauthorization in 2015.

3.2.5. Other Federal Issues

Sequestration

The Budget Control Act of 2011 mandated annual across-the-board federal budget reductions, also known as sequestration. The Act requires cuts over federal fiscal years 2013–2021 equaling an estimated $109 billion per year split equally between defense and non-defense spending. The Bipartisan Budget Act of 2013 extended the reductions an additional two years, through 2023. Both discretionary and mandatory programs are subject to sequester; however, some programs from each budget segment are exempt, including Medicaid, the Children's Health Insurance Program (CHIP), and the Temporary Assistance for Needy Families (TANF) program. Cuts to Medicare and certain health programs are limited to two percent.

Sequestration impacts programs and services across the Texas Health and Human Services (HHS) System. In the 2014–2015 biennium, the HHS System agencies are managing sequester reductions to non-exempt mandatory and discretionary funding within existing appropriations to minimize the impact to client services. Future decreases in funding to these covered programs may result in reductions in numbers of clients served and levels of services provided. Estimates of future year reductions are not possible, as the exact reduction depends on the base determined as subject to sequestration. Many factors, including level of growth in mandatory programs, may impact the calculations. Congress could enact legislation at any time that repeals the law or modifies the exemptions or rules associated with sequestration.

Chapter 4

Health and Human Services System Cross-Agency Coordination

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

Each of the agencies in the HHS System has planning responsibilities that are described in the following sections. Some of the planning efforts, such as the HHS System workforce plan, are the responsibility of all System agencies, while others, such as the Task Force for Children with Special Needs, involve a subset of System agencies.

The material in this chapter is arranged as follows:

- Strategic Plans and Initiatives;
- Services for Adults and Children with Disabilities;
- Focusing on Identified Issues;
- Councils, Committees, and Task Forces; and
- Operational Coordination and Process Improvements.

Each of the next chapters is the Strategic Plan for each individual agency in the HHS System, beginning with the Health and Human Services Commission. Each chapter discusses the agency's external assessment, internal assessment, and current activities by goal.

4.1 Strategic Plans and Initiatives

4.1.1 Coordinated Strategic Plan for Health and Human Services

The Coordinated Strategic Plan (CSP) for Health and Human Services serves as the Strategic Plan for the Health and Human Services (HHS) System. The CSP requirement, in Section 531.022 of the Texas Government Code, preceded House Bill (H.B.) 2292 (78-R) and it required the legacy health and human services agencies to produce a single plan addressing challenges and opportunities that these agencies shared. During that time, the CSP was completed after each agency had prepared its individual agency Strategic Plan.

Since the enactment of H.B. 2292 (78-R) 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 through 4 of this document constitute the CSP. Since all of the System agencies have contributed to this Plan, Health and Human Services Commission is using its authority to consolidate reports (granted at Texas Government Code, Section 531.014) to satisfy the CSP requirement. Development of this Plan met the requirements for public comment on the CSP, as required by Texas Government Code Section 531.036. The final Plan will be provided to all the indicated recipients for the CSP in July, prior to the CSP due date of October 1, 2014.

4.1.2 Technology Resources Planning

As part of gaining maturity in aligning information technology (IT) efforts with business needs across the Enterprise, the five Health and Human Services (HHS) System agencies' IT groups use an IT governance structure through which business representatives give guidance on IT projects, applications, and contracts. The governance structure consists of:

- Five HHS System portfolios:
  - Administrative systems,
  - Infrastructure/shared services,
  - Medical client systems,
  - Social services systems, and
  - Health services systems;
- An upper level that makes decisions that cross all the portfolios;

- A foundation layer that supports the portfolios with technology and security standards (gathered from the 2014–2018 State Strategic Plan for Information Resources Management, industry research, and consultation with other IT groups at federal, state, and local governments and private entities); and
- Additional governance activities at each agency.

Committees for each of the portfolio governing bodies include appropriate membership from the senior levels of agency leadership.

The five HHS System Information Resources Managers have also coordinated tactical projects for fiscal year (FY) 2014 to accomplish the guidance given by the governance process, and HHS System IT organizations are developing a three-year roadmap (FY 2015 through FY 2017) for each portfolio to align the strategic governance direction with tactical, operational projects to move the HHS System toward the desired outcomes. These projects are delineated in Appendix I, "Technology Initiative Assessment and Alignment."

4.1.3 Health and Human Services System Strategic Staffing Analysis and Workforce Plan

Chapter 2056.0021 of the Texas Government Code requires state agencies to conduct a strategic staffing analysis and to develop a workforce plan, according to guidelines developed by the State Auditor. The Health and Human Services (HHS) System Strategic Staffing Analysis and Workforce Plan addresses critical staffing and training needs of the agencies, including the need for experienced employees to impart knowledge to their potential successors. This workforce plan for the HHS System agencies is included as Appendix E of this Strategic Plan.

4.1.4 Texas Workforce Development System Strategic Planning/Strategic Relationship with Workforce System

The Texas Workforce Investment Council (TWIC) serves as the federal Workforce Investment Act's mandated State Workforce Board. In addition, state law requires TWIC to develop a strategic plan for the Texas workforce system that establishes the framework for budgeting and operating a workforce development system administered by agencies represented on the council. As one of the agencies in the Texas workforce system, the Department of Assistive and Rehabilitative Services (DARS) participates in the strategic planning process and provides certain performance measures for inclusion in the TWIC plan, including consumers served, employment retention, and number of consumers who entered employment. The workforce system strategic plan is periodically updated to indicate accomplishments

and milestones achieved, in addition to other applicable changes to the action plans and associated agency project plans. The current workforce system strategic plan is *Advancing Texas: Strategic Plan for the Texas Workforce System (FY2010-FY2015)*. Current DARS activities that align with *Advancing Texas* are included as Appendix H.

4.1.5 Border Regions Initiatives

In the late 1990s, Texas lawmakers became concerned about the need for enhanced services in some Texas border regions, designated by Senate Bill 501 (76-R).[1] Figure 4.1 illustrates these designated regions.

The populations of both the Texas-Mexico and the Texas-Louisiana border regions are growing. From 2015 to 2019, the population in the 43 counties comprising the Texas-Mexico border region is expected to grow at a rate slightly lower than the state's population as a whole (7.6 percent versus 8.4 percent). The rate of population growth in the 18 counties in the Texas-Louisiana border region is projected to increase at a considerably lower rate (4.6 percent) compared to the Texas-Mexico border counties. In these two border areas, 30 counties are geographically isolated and economically distressed, which represents 70 percent of the total number of counties in the combined regions.

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

Figure 4.1
Designated Border Regions
According to Senate Bill 501 (76-R)

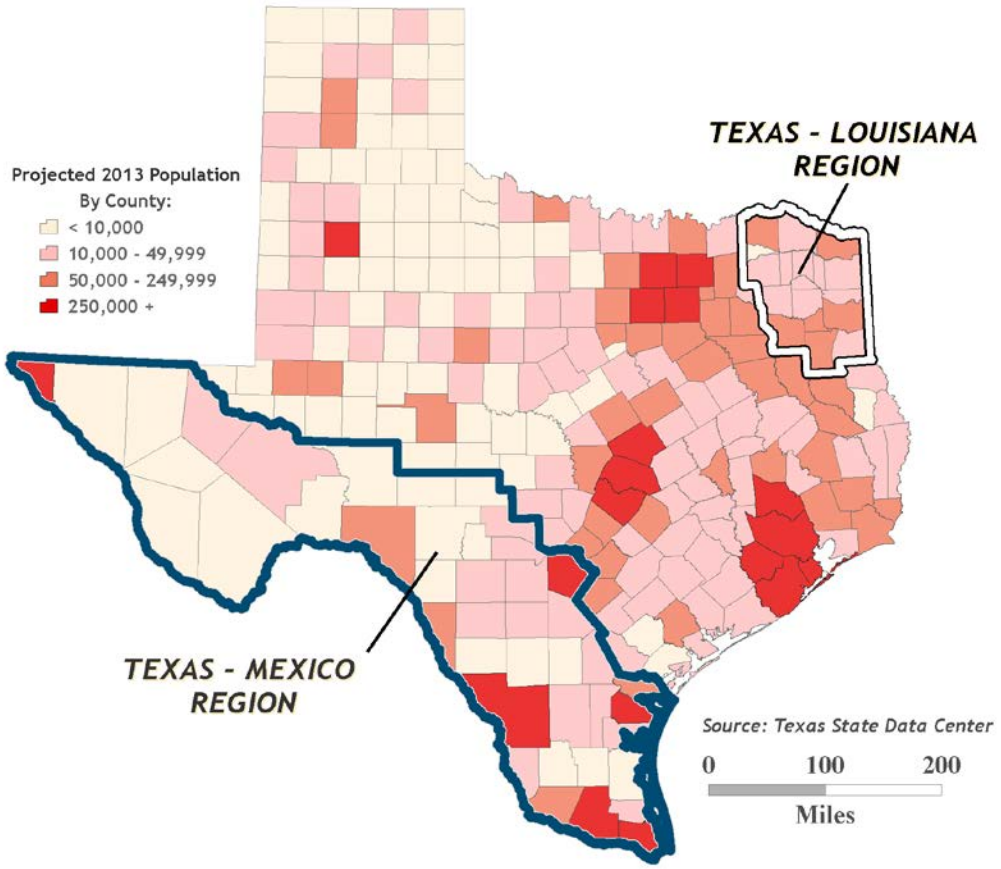

Figure 4.1: Health and Human Services Commission - Strategic Decision Support, 2012.

Texas-Mexico Border Region

The Texas-Mexico border extends approximately 1,250 miles along the Rio Grande River, from Ciudad Juarez/El Paso to Matamoros/Brownsville. It is projected that in 2015, the population of this region will represent approximately 20 percent of Texas' total population. Spanish is spoken in more than three-quarters of this region's households. The estimated poverty rate for this region in 2012 is 24.8 percent, which is considerably higher than the estimated rate for the state as a whole, which is estimated at 17.9 percent. High levels of poverty in a population or region generally result in a higher demand for health and human services.

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, telephone service, and internet access. Due to these factors, access to health services is also a challenge. Today, more than 2,200 colonias exist in the area located primarily along the state's 1,248 mile border with Mexico.

The Health and Human Services Commission (HHSC) Office of Border Affairs was created to ensure coordination of services and supports for those living in the Texas border regions. The Health and Human Services (HHS) System agencies have developed an interagency partnership with the Office of Border Affairs, the Texas Workforce Commission, local workforce development boards, the Texas Education Agency, local school districts, and education service centers. The partnership, which has expanded to include community-based organizations, faith-based organizations, local, state and federal government agencies, 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 System 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/Zapata, and the Rio Grande Valley. Additionally, each region includes HHS System promotoras, who are community health workers contracted through several vendors.

The Department of State Health Services (DSHS) participates in border health functions, working together with partners in the United States and Mexico. More information is available in the DSHS Strategic Plan, Chapter 9 of this document, under the heading "Border Health."

Texas-Louisiana Border Region

On the Texas-Louisiana border, 18 counties are designated by law for enhancement of service delivery. Together, the counties encompass 11,448 square miles, including most of the area in the HHS System region known as Upper East Texas. It is projected that in 2015 the population of this region will represent 3.3 percent of the total Texas population.

The results from the 2010 Census of Population indicate that African Americans are the largest ethnic minority group in this region. In 2010, this group represented 16.8 percent of the region's total population. According to population projections developed by the Texas State Data Center, African Americans will continue to be the largest ethnic minority group in the region during the short-term future, representing 16.6 percent of the region's total population in 2015 and 16.3 percent in 2019.

The 2012 poverty rate for the region is estimated at 18.5 percent, which is slightly higher than the poverty rate for the state as a whole, which is estimated at 17.9 percent.

4.2 Services for Adults and Children with Disabilities

4.2.1 Texas Promoting Independence Initiative and Plan

The Texas Promoting Independence Initiative began in response to the United States Supreme Court decision in *Olmstead vs. L.C.* (June 1999) and Governor George W. Bush's Executive Order GWB 99-2. The purpose of the initiative is to promote an individual's choice to live in the most integrated residential setting to receive appropriate long-term services and supports. While this is an initiative of the Health and Human Services Commission (HHSC), the agency has delegated daily management of the initiative to the Department of Aging and Disability Services, through Health and Human Services (HHS) System Circular-002: The Promoting Independence Initiative and Plan. Executive Order GWB 99-2 required that a report be submitted to the Governor's Office by January 2001, making recommendations regarding services for individuals with disabilities. HHSC established a statewide advisory committee to guide the development of this report, named the Texas Promoting Independence Plan.

Many of the components of GWB 99-2 and the plan were codified by Senate Bill (S.B.) 367 (77-R). This bill required the permanent establishment of a statewide advisory committee, which is known as the Promoting Independence Advisory Committee, and the submittal of a revised Texas Promoting Independence Plan to the Legislature every two years, in the December prior to a legislative session. In addition, S.B. 367 (77-R) required that the committee submit an annual stakeholder report to the HHSC Executive Commissioner at the beginning of each fiscal year.

The annual stakeholder report provides input on the committee's policy concerns and a status report on the progress made by each of the HHS System agencies.

In April 2002, Governor Rick Perry issued Executive Order RP-13, which further reinforced the initiative and stated that both the Texas Department of Housing and Community Affairs and the Texas Workforce Commission would cooperate to support the initiative and have staff participate on the committee. The latest plan is the 2012 Revised Texas Promoting Independence Plan—December 2012.

The committee is currently monitoring more than 24 recommendations for changes across the HHS System, and it also helps the state oversee the Money Follows the Person Demonstration. This demonstration, considered to be one of the most successful in the country, is a national long-term services and supports rebalancing initiative to help states enhance their community-based system to allow individuals a choice in where they want to live.

4.2.2 Employment Services

The Department of Assistive and Rehabilitative Services (DARS) helps Texans with disabilities find jobs through vocational rehabilitation services. Employment services are also offered through other Health and Human Services (HHS) System agencies. DARS partners with those HHS System agencies, other state agencies, and community organizations providing direct services related to employment for people with disabilities. Collaboration is important to successful long-term employment outcomes. DARS has a Memorandum of Agreement (MOA) with each of the Department of Aging and Disability Services and the federal Veterans Administration to help coordinate the delivery of employment services. DARS and the Department of State Health Services are also in the process of developing an MOA regarding the delivery of employment services.

Several recent bills highlight the importance of coordinating employment services through the HHS System and with other state agencies: Senate Bill (S.B.) 7 (83-R), S.B. 45 (83-R), S.B. 1226 (83-R), and House Bill 617 (83-R).

4.2.3 Texas Office for Prevention of Developmental Disabilities

The Texas Office for the Prevention of Developmental Disabilities (TOPDD) is a public-private partnership created to minimize the economic and human losses in Texas caused by preventable disabilities.

TOPDD educates organizations and individuals about the significance of preventable disabilities and what they can do about them, individually and collectively. TOPDD's work encompasses professional training and education, data gathering and analysis, needs assessment, service coordination, and consultation services.

As the hub for the prevention of developmental disabilities, TOPDD operates across the full spectrum of health and human service organizations. To develop coordinated plans and messaging to the public, it brings together experts in a variety of fields: medical, the judiciary, mental health, child advocacy, education,

disabilities, scientific, academia, chemical dependency treatment/recovery, and consumer/stakeholder groups. The organizations involved in this collaborative effort include public and private agencies that operate on the state, county, regional, and local levels. TOPDD also works with federal agencies, national organizations, researchers, and entities in other states so that Texas has the benefit of the most current information in the field.

Overseen by an executive committee, TOPDD raises funds independently and develops a unified, comprehensive prevention effort in Texas that addresses the following objectives:

- Reduce the incidence and severity of developmental disabilities,
- Establish a mechanism by which prevention activities can be coordinated better and prevention activities can be initiated, and
- Minimize the economic and human losses in Texas caused by preventable developmental disabilities.

TOPDD is currently concentrating on fetal alcohol spectrum disorders, child safety and injury prevention, and policy development related to the co-existence of developmental disabilities and mental health needs of children.

TOPDD's fundraising ability has allowed it to build on the funds that the state provides and has increased TOPDD's reach and ability to connect with stakeholders whose policies, operations, and procedures can prevent developmental disabilities and assist families and consumers who are impacted by developmental disabilities.

4.2.4 Office of Acquired Brain Injury

The Office of Acquired Brain Injury (OABI) is the state's primary resource to provide education, awareness, prevention and service referral and coordination to brain injury survivors, families and caregivers, brain injury service providers, Texas Military Forces and Veterans, and other state, federal, local and private agencies. The office provides direct communication and coordination with consumers, state and federal elected officials on behalf of constituents, and the Health and Human Services (HHS) Ombudsman Office.

The Traumatic Brain Injury Advisory Council is the advisory council to the OABI as required by Texas Health and Safety Code §92.052. The council works to:

- Inform state leadership of the needs of people with brain injuries and their families;
- Recommend policies and practices that more effectively meet those needs;
- Encourage research into the cause, prevention, and treatment of traumatic brain injury and care of people with a traumatic brain injury;

- Promote brain injury education, prevention, and awareness throughout the state; and
- Identify people with traumatic brain injuries, their family members and caregivers to improve their access to supports and services.

The council is composed of 22 members including eight public consumer members, six professional members, and representatives from the Health and Human Services Commission, the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Texas Education Agency, the Texas Department of Insurance, and the Texas Planning Council for Developmental Disabilities.

An acquired brain injury (ABI) is an injury that occurs after birth, is non-congenital and non-degenerative, and prevents the normal function of the brain. The designation ABI includes traumatic brain injury (TBI), which is the result of a blow or jolt to the head or a penetrating wound. ABI 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. Brain injuries are categorized as mild, moderate or severe. A concussion is a brain injury, usually mild to moderate.

ABIs affect cognitive, behavioral, physical, emotional, and social abilities and often have catastrophic economic impact on the individual and/or family. A 2010 Rand report related that the economic impact of brain injury in Texas was $6.8 billion for survivors alone. This does not account for financial/social impact on family members through lost wages, possible unemployment, possible loss of insurance benefits, and other factors. Infants, children, and youth who sustain brain injuries may have temporary or permanent deficits in brain development that may impair daily living skills and their ability to live independently. A brain injury at an early age may also lead to poor performance in school, anxiety, depression, substance abuse, and criminal behavior.

Brain injury is considered the third major health issue following cardiovascular disease and cancer. The Centers for Disease Control and Prevention (CDC) predicts that by 2020 brain injury will be the leading cause of death and disability in the United States. 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, acquired immunodeficiency syndrome (AIDS), multiple sclerosis, and spinal cord injury combined. Populations at the highest risk for brain injury are infants and children from birth through age 4, adolescents (predominantly male) ages 16 to 25, and adults older than age 65.

The CDC's TBI Registry reports that more than 155,000 Texans sustained a TBI in 2012. This number, gathered from Texas hospital discharge data, reflects only individuals who were admitted for at least 23 hours and only for TBI. It does not include individuals who were treated and released by emergency departments,

primary or family physicians, urgent or neighborhood clinics or other medical treatment facility or who sought no treatment.

The OABI bridges resources across local, state, and federal entities. The office serves as a critical link in cross-agency and external service delivery through coordination and referral as well as brain injury awareness, prevention, and education. The office reviews and assesses existing programs across the HHS System and elsewhere to determine and address gaps and duplication of services.

Major OABI initiatives include:

- The Texas TBI Juvenile Justice Screening Pilot Project, funded by a federal grant of $1 million;
- A law enforcement guide for working with veterans with TBI, post-traumatic stress disorder, and homelessness;
- Training about brain injury for caregivers and others, including 2-1-1 Texas personnel, Texas Military Forces, family members, caregivers, and brain injury professionals;
- A resource document for assisting with re-entry of students with a brain injury to the classroom;
- A handbook for disaster and emergency preparedness and response management teams;
- Web-based continuing education courses for public health workers, law enforcement, consumers, and professionals;
- Focus on outreach, dissemination, and education;
- Pursuit of federal grant opportunities focusing on veterans' services, deepening the office's health resource and referral processes for that population, advanced training and resource materials for families and health providers, and specific supports for veterans and their families; and
- Focused work with the State Athletic Trainer's Association, creating specific resources, outline tools, and education materials for parents, coaches and school personnel around brain injuries connected to youth sports.

4.2.5 Family-Based Alternatives

The Family-Based Alternatives project was established by Senate Bill 368 (77-R) to create family-based alternatives to institutional care for children with disabilities.

Administered by the Health and Human Services Commission, the project assists children living in institutions to return 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 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 and nursing facilities has declined by 50 percent, and more than 2,000 children have moved from institutions into families or family-based alternatives.

4.2.6 Community Resource Coordination Groups of Texas

Community Resource Coordination Groups (CRCGs) originated with Senate Bill (S.B.) 298 (70-R) 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. The Health and Human Services Commission provides state-level coordination of CRCGs.

S.B. 1468 (77-R) 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 elected to develop a separate group to serve adults. Organized by counties, some CRCGs serve several counties, while others provide services in a single county.

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 people served by the Health and Human Services (HHS) System. The groups can include representation from the HHS System agencies, the criminal or juvenile justice systems, the education system, housing agencies, the workforce system, local service providers, and families.

The CRCG Program received funding from the 83rd Legislature in 2013 to support one staff position and a website and enhanced database so local CRCGs can input data related to coordination meetings and other activities to serve individuals and families. The resources allow the agency to provide support and strengthen active CRCGs and to revitalize those that have been less active.

Mental health care is the most frequently identified service need for children and youth referred to local CRCGs. These children and youth often require a comprehensive array of intensive services, such as mental health care, interpersonal and coping skills development, family support, social interaction, basic needs, self-sufficiency, substance abuse treatment, and education.

4.2.7 Texas Autism Research & Resource Center

Created by House Bill 1574 (81-R), the Texas Autism Research & Resource Center (TARRC) is to provide greater support to individuals with autism spectrum disorder and their families. Guiding all TARRC initiatives is a consortium of people and organizations across Texas who have a special interest in autism services and research. The consortium includes:

- Staff from the state agencies that develop and manage Texas' autism programs,
- Nationally-recognized researchers,
- Administrators of university-based autism programs,
- Autism specialists working in education service centers, and
- Individuals representing organizations that serve and advocate for people with autism and their families.

Formed in the fall of 2009 to help plan for TARRC, the consortium today plays a fundamental role in the TARRC's activities and development. Since its inception, consortium members have worked with TARRC staff on several activities:

- Developing a comprehensive website, www.tarrc.org, that directs Texans to all state and federal programs available to assist individuals and families affected by autism;
- Planning, organizing, and implementing TARRC's annual autism research conference; and
- Designing other initiatives to further the center's work and goals.

Through its ability to share information on autism research, services, and local community needs, the TARRC consortium has effectively become a new statewide network for discussion of autism concerns and related topics.

The annual Texas Autism Research Conference, sponsored by the TARRC, focuses on cutting-edge research about autism. Targeted to academics, researchers, licensed professionals, and individuals with a special interest in autism research, the TARRC conference provides information on a variety of research topics, such as possible causes of autism and early intervention techniques. The conference addresses multiple aspects of research, including individual research studies, applied research initiatives, and evidence-based treatment practices.

4.3 Focusing on Identified Issues

4.3.1 Controlled Prescription Drug Monitoring Project—Prescription Access Texas System

The nation is dealing with an escalating prescription drug epidemic that now claims more lives every year than car crashes. In 2012, the Health and Human Services Commission received a $450,000 three-year grant from the Substance Abuse and Mental Health Services Administration to support a controlled prescription drug monitoring project (PDMP), a statewide electronic database to collect designated data on substances dispensed in Texas. The project funded through this grant is called the Health Exchange Leveraging PDMP, or HELP for Texans. This project, coordinated with the Department of Public Safety (DPS), will connect the PDMP managed by DPS to the state's health information exchange (HIE) network, HIETexas, managed by the Texas Health Services Authority.

Recognizing the importance of HIE interoperability, the Legislature passed Senate Bill1643 (83-R), relating to the monitoring of prescriptions for certain controlled substances. This bill explicitly allows the state's prescription access system to share data with specified providers using HIEs. This allows data to be transferred and incorporated into an electronic medical record. The bill also defined HIE in state law.

4.3.2 Data-Sharing to Reduce Preterm Births

The Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) are working jointly on an initiative designed to provide managed care organizations with information to help them improve the focus on women of childbearing age who have had a previous preterm birth. Using a matching process, HHSC Medicaid eligibility files are matched against the DSHS birth records database on a monthly basis, and information on Medicaid enrollees with a prior preterm birth, as well as other complications during delivery, are shared with managed care organizations. Managed care organizations are then able to target their enrollees for possible intervention/treatment.

4.3.3 Psychotropic Medication Monitoring

In September 2004, the release of a Health and Human Services Commission (HHSC) Office of Inspector General report raised concerns regarding the use of psychotropic medications among Texas children in foster care. Since then, HHSC, the Department of State Health Services (DSHS), and the Department of Family and

Protective Services (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 has included several efforts.

- **Psychotropic Medication Utilization Parameters for Foster Children—**This publication of best practice parameters, or guidelines, was released in February 2005 and has been updated biennially. The most recent update, the fourth edition, was released in September 2013.
- **Annual analysis of how Medicaid prescribing practices align with these guidelines—**Analysis has revealed that psychotropic prescribing to children in foster care has decreased by 34 percent since the release of the guidelines in early 2005.
- **Psychotropic Medication Utilization Reviews—**In April 2008, HHSC implemented the STAR Health program, a statewide Medicaid managed care program that provides comprehensive care to children in Texas foster care. STAR Health conducts ongoing Psychotropic Medication Utilization Reviews (PMURs) for foster children whose medication regimens fall outside of the parameters suggested.
- **Quality of Care Reviews—**STAR Health thoroughly reviews physicians who consistently prescribe outside parameters, as identified through the PMUR process. The PMUR team refers these physicians to the STAR Health Credentialing Committee for further investigation and action. A Quality of Care Review covers any additional medical records requested and a peer-to-peer interview with the prescriber. The committee may determine that a physician should be placed on a corrective action plan, which could include disciplinary action up to and including termination from the network.
- **Psychotropic medication utilization monitoring for children who are eligible for both Medicaid and Medicare or living in Texas under the Interstate Compact on the Placement of Children—**Effective September 1, 2013, House Bill (H.B.) 915 (83-R) requires HHSC to monitor the psychotropic medication utilization of two populations of children: those in DFPS conservatorship who are dually eligible for Medicaid and Medicare, and those who are in conservatorship from another state and placed in Texas under the Interstate Compact on the Placement of Children (ICPC). The HHSC Medicaid Vendor Drug Program Pharmacy Utilization Review contractor conducts these reviews using Medicaid data. DFPS notifies the home state of any child placed in Texas under ICPC when the medication regimen is outside parameters. The bill also requires a medical consenter—a person authorized to consent to medical treatment for a foster child who is prescribed a psychotropic medication—to ensure the child has a visit with the prescribing physician, physician assistant, or advanced practice nurse at least once every 90 days.
- **Psychotropic Medication Consent—**Effective September 1, 2013, as part of DFPS' implementation of H.B. 915 (83-R), medical consenters are required to attend psychotropic medication appointments in person and to complete the

"Psychotropic Medication Consent Form" for each new medication. DFPS has also revised policy to require caseworkers to notify parents of the initial prescription of psychotropic medications, and any dosage changes, at the next scheduled meeting of the parents and the caseworker.

- **Quarterly meetings of a Psychotropic Medication Monitoring Group—**With representatives from DFPS, HHSC, DSHS, the University of Texas School of Pharmacy, and the administrator of the STAR Health program, this group reviews 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.

4.3.4 Antipsychotic Prescribing Quality Measures

This project was formerly the Medicaid Network for Evidence-Based Treatment (MEDNET) project which is discussed. The MEDNET project began as a multistate collaborative grant from the Agency for Health Research and Quality, a unit of the federal Department of Health and Human Services, administered by Rutgers University. The objective was to identify and target best practices and opportunities for quality improvements in the area of antipsychotic prescribing and mental health care. The overall goal was to improve clinical quality care and patient safety, and to achieve cost savings.

When the grant ended, the project work became a subsequent study in collaboration with the University of Texas College of Pharmacy. The new study is focused on three targeted analyses of psychotropic medication use in clients enrolled in the Texas Medicaid program. The project is coordinated with the Department of Family and Protective Services, the Department of State Health Services, and the Medicaid program.

The Health and Human Services Commission continues to interface with managed care organizations and to share data on specific quality measures that were designed for the project. It is anticipated that this project will present opportunities to help support quality monitoring of managed care organizations, mental health rehabilitation, and targeted case management services "carve-in" mandated by Senate Bill 58 (83-R).

4.3.5 Texas System of Care Grant

Through a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health and Human Services Commission (HHSC) and agency partners developed a statewide strategic plan to expand the federally-

endorsed system of care model for children and youth with complex mental health needs and their families.

HHSC is expanding system of care practices statewide with the support of an additional four-year cooperative agreement with SAMHSA. This work includes partnerships with communities that have received or are receiving SAMHSA community grants (four past grants and two current grants). HHSC is working with two additional system of care expansion communities helping inform the planning and preparations for improving cross-agency service delivery and community readiness to continue to expand this model.

The Texas System of Care Consortium was created under Senate Bill 421 (83-R). The consortium is comprised of six state child- and youth-serving agencies and at least one public member (a parent or youth representative with lived experiences of accessing and using mental health services) who provides oversight to the implementation of statewide system of care expansion.

4.4 Councils, Committees, and Task Forces

The Health and Human Services System 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 and behavioral health system to meet future needs. Examples are noted below.

4.4.1 Health and Human Services Commission

Texas Institute of Health Care Quality and Efficiency

The Texas Institute of Health Care Quality and Efficiency (IHCQE) was established by Senate Bill (S.B.) 7 (82-1) “to improve health care quality, accountability, education, and cost containment in this state by encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services.” The IHCQE leverages its unique public/private, multi-stakeholder, multi-agency structure to engage the commercial, non-profit, and public sectors to develop and facilitate high-value recommendations and collaborative projects that catalyze sustained improvement in health care quality, accountability, education, and cost containment for Texas. Institute activities support a vision for optimizing health system performance through three aims: to enhance Texans’ experience of care, to improve the health of the population, and to reduce trends for per-capita health care cost growth.

The institute draws expertise from its diverse Governor-appointed board that is composed of health care providers, payors, consumers, and health care quality experts, in addition to representatives from several state agencies. The board develops legislative recommendations, provides a forum for information sharing, and supports projects aimed at enhancing patients' experience of care, improving the health of the population, and reducing trends in per capita health care cost growth. The institute's current strategic focus includes:

- Promoting informed health and wellness decision-making by Texans;
- Improving transparency on the cost and quality of health care;
- Encouraging team-based care delivery models and value-based reimbursement; and
- Promoting productivity gains through greater use of high value services, including non-medical, community-based, and public health interventions.

The IHCQE board includes ex officio representation from nine state agencies and six public university systems with significant administrative, service delivery, and research interests in the health care system. This board structure provides a forum for multiple agencies to exchange information and work collaboratively to pursue health care quality improvement initiatives. For example, the IHCQE is partnering with the Health and Human Services Commission (HHSC), the Texas Department of State Health Services (DSHS), the Texas Department of Aging and Disability Services (DADS), the University of Texas School of Public Health, and the Meadows Mental Health Policy Institute to build a comprehensive, cross-agency database of the adults receiving Medicaid who have serious and persistent mental illness. This partnership will result in an analytical report describing service utilization patterns for this population, the identification of promising and best practices to inform the integration of behavioral health services into Medicaid, and the development of relevant policy recommendations.

Texas Coordinating Council for Veterans Services

The Texas Coordinating Council for Veterans Services was created by S.B. 1796 (82-R) to coordinate the activities of state agencies that assist veterans, service members, and their families. The United States Department of Veterans Affairs estimates that there are more than 1.6 million veterans in Texas. The council’s first biennial report was submitted to the Legislature in October 2012.

After the first year of meeting, it was evident that there were some agencies that were not originally included in the statute that play a big role in providing veterans' services. S.B. 1892 (83-R) added the following entities:

- HHSC’s Office of Acquired Brain Injury,
- DSHS,
- DADS,
- The Department of Assistive and Rehabilitative Services,

- The Department of Family and Protective Services (DFPS),
- The Texas Workforce Commission,
- The Texas Workforce Investment Council,
- The Texas Higher Education Coordinating Board,
- The Texas Department of Licensing and Regulation,
- The Department of Public Safety,
- The Texas Department of Criminal Justice,
- The Commission on Jail Standards,
- The Commission on Law Enforcement Officer Standards and Education,
- The Texas Department of Housing and Community Affairs,
- The Texas Department of Transportation,
- The Texas Department of Motor Vehicles, and
- The Office of Public Utility Counsel.

S.B. 1892 (83-R) also added a transportation workgroup and a women veterans' workgroup to the list of coordinating workgroups that the council is authorized to establish, by majority vote, to focus on specific issues affecting veterans, service members, and their families. The members of the council also elected to establish an eighth workgroup to focus communication and outreach to veterans.

Eight coordinating workgroups focus on specific issues affecting veterans, service members, and their families:

- Health,
- Criminal Justice,
- Higher Education,
- Housing,
- Employment,
- Women Veterans,
- Transportation, and
- Communication and Outreach.

In addition to compiling an inventory of veterans' services provided by state agencies, the workgroups will identify the strengths and weaknesses of these services and will make recommendations for better coordination and outreach. The council will collaborate with state, federal, and local agencies and private organizations. The work of the council and workgroups will be compiled in a report, due October 1, 2014 and every even-numbered year thereafter, presenting findings and recommendations to the Governor and Legislature on improving services to Texas veterans.

Post-Traumatic Stress Disorder Study in Veterans

HHSC and DSHS spearheaded and implemented a pilot to study treatment modalities for post-traumatic stress disorder in the veteran population. The project also involves working with the University of Texas at Dallas, University of Texas Southwestern, and a contractor as part of the study. Consistent with the Health and Human Services System's strategic priority to improve and protect the health and well-being of Texans, identifying promising treatment services for veterans will lead to increased self-sufficiency and independence.

Behavioral Health Integration Advisory Committee

The Behavioral Health Integration Advisory Committee, created by S.B. 58 (83-R), is charged with addressing planning and development needs to integrate Medicaid behavioral health and physical health services, including targeted case management, mental health rehabilitative services, and physical health services, by September 1, 2014. The committee must seek input from the behavioral health community on these issues and produce formal recommendations to HHSC on how to accomplish integrating behavioral and physical health within Medicaid managed care.

Perinatal Advisory Council

The Perinatal Advisory Council, created by House Bill (H.B.) 15 (83-R), continues the work of the former Neonatal Intensive Care Unit Council established by the 82nd Legislature. The council is charged with developing recommendations for a statewide hospital designation process and standards for levels of neonatal intensive care units (NICUs) and maternity care, and tying these standards to Medicaid reimbursement. The council also will examine utilization trends in neonatal and maternal care, and it will propose ways to improve quality outcomes for neonatal and maternal care in hospitals. This effort will include recommendations for dividing the state into perinatal and NICU regions.

HHSC will collaborate closely with DSHS on this project to ensure DSHS regulatory and designation activities are coordinated with the Medicaid system. In addition, the council will submit a report with recommendations to HHSC and DSHS in September 2015.

Quality-Based Payment Advisory Committee

The Quality-Based Payment Advisory Committee advises HHSC on several topics:

- Establishing Medicaid and Children's Health Insurance Program reimbursement systems to reward the provision of high-quality, cost-effective health care, quality performance, and quality-of-care outcomes with respect to health care services;

- Developing standards and benchmarks for quality performance, quality-of-care outcomes, efficiency, and accountability by managed care organizations and health care providers and facilities;
- Developing programs and reimbursement policies that encourage high-quality, cost-effective health-care delivery models that increase appropriate provider collaboration, promote wellness and prevention, and improve health outcomes; and
- Developing outcome and process measures which can be used to support these endeavors.

STAR+PLUS Quality Council

The STAR+PLUS Quality Council, created by S.B. 7 (83-R), assesses quality and recommends improvements to ensure STAR+PLUS Medicaid consumers receive quality, person-centered, consumer-directed acute care and long-term services and supports in the most integrated setting achievable. The council submits a report to the HHSC executive commissioner, and they share these assessments and recommendations with the Legislature in even-numbered years.

The Intellectual and Developmental Disability System Redesign Advisory Committee

The Intellectual and Developmental Disability (IDD) System Redesign Advisory Committee will advise HHSC and DADS on implementing the acute care services and long-term services and supports (LTSS) system redesign for individuals with IDD. Goals include the following.

- Provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs.
- Improve individuals' access to services and supports by ensuring that the individuals receive information about all available programs and services, including employment and least restrictive housing assistance, and how to apply for the programs and services.
- Improve the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs.
- Promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment.
- Promote individualized budgeting based on an assessment of an individual's needs and person-centered planning.
- Promote integrated service coordination of acute care services and LTSS.
- Improve acute care and LTSS, including reducing unnecessary institutionalization and potentially preventable events.
- Promote high-quality care.

- Provide fair-hearing and appeals processes in accordance with applicable federal law.
- Ensure the availability of a local safety-net provider and local safety-net services.
- Promote independent service coordination and independent ombudsman services.
- Ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization of individuals.

STAR Kids Advisory Committee

The STAR Kids Medicaid Managed Care Advisory Committee advises HHSC on the establishment and implementation of the STAR Kids Medicaid managed care program. The STAR Kids program will provide Medicaid services for children and young adults with disabilities through a managed care model. The program intends to improve coordination, customization, and access to care, and to improve health outcomes, cost containment, and quality of care. The STAR Kids model will provide a health home, care management, and comprehensive coordination of acute care and long-term service benefits. The STAR Kids Advisory Committee includes parents, providers, representatives from managed care organizations (MCOs), and representatives of non-profit organizations.

State Medicaid Managed Care Advisory Committee

The State Medicaid Managed Care Advisory Committee provides recommendations and ongoing input to HHSC on the statewide implementation and operation of Medicaid managed care. The committee reviews program design and benefits, systemic concerns from consumers and providers, efficiency and quality of services delivered by Medicaid MCOs, contract requirements for Medicaid managed care, provider network adequacy, and trends in claims processing.

The committee also will help HHSC with policies related to Medicaid managed care and will share information on best practices with the Medicaid Regional Advisory Committees. The committee serves as the central source for stakeholder input on the implementation and operation of Medicaid managed care.

STAR+PLUS Nursing Facility Advisory Committee

The STAR+PLUS Nursing Facility Advisory Committee will advise HHSC on implementation and associated activities related to Medicaid services provided to individuals who reside in nursing facilities and are members of STAR+PLUS managed care program.

Task Force on Domestic Violence

Established by H.B. 2620 (83-R), the Task Force on Domestic Violence is a 25-member body charged with developing recommendations for improving the ability of the health care system to prevent and identify domestic violence among certain populations. The task force's work is focused on pregnant women, mothers with children age two and younger, and children age two and younger.

HHSC will be collaborating with DFPS and DSHS on activities of the task force. Members include representatives from state agencies, family violence centers from both urban and rural areas, statewide advocacy organizations, and multiple statewide medical associations. A report with task force findings and legislative, policy, and research recommendations must be submitted to state leadership by September 1, 2015. Pursuant to H.B. 2620 (83-R), the task force is abolished on January 1, 2016.

Children's Policy Council

The Texas Children's Policy Council (CPC) was created by H.B. 1478 (76-R) to assist the HHS System in developing, implementing, and administering family support policies and related long-term care and health programs for children with disabilities. S.B. 50 (83-R) increased the CPC's scope by adding children's mental health to its core work. The council is required to report its findings and recommendations to the Legislature and the HHSC Executive Commissioner no later than September 1 of each even-numbered year.

The CPC's mission is to promote and advocate for public policies that support families of children with disabilities, enabling their children to grow up in families, be an integral part of their communities, and meet their potential. The CPC has a prescribed membership with a majority membership of family members, and the remaining members are drawn from the community sector. S.B. 50 (83-R) added additional members, bringing expertise from mental and behavioral health. The bill added an individual who is younger than age 25 and who receives or has received mental health services, and it added representation from relatives of consumers of long-term care and health programs for children age 26 or younger.

S.B. 7 (83-R) further expanded the role of the CPC by requiring HHSC to utilize the CPC as a resource in developing the STAR Kids managed care model for children with disabilities.

The CPC has made presentations and reports to state agencies on long-term care reform, Medicaid managed care reform, and managed dental care for children with disabilities. As a result, HHSC and the CPC are working together to develop a parent guide to the use of and issues surrounding durable medical equipment. Additionally, the CPC has presented several educational sessions to legislators. In February 2014, the CPC presented a full set of recommendations for the STAR Kids

model to HHSC and will be working to incorporate them into the draft and final request for proposal and presenting to the STAR Kids Managed Care Advisory Committee in June of 2014.

Council on Children and Families

S.B. 1646 (81-R) 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. The council is administratively attached to HHSC but is independent in its direction. Council members include the chief executive officers, or their designees, of nine state agencies serving children, along with four public members appointed by the HHSC Executive Commissioner.

The council is charged with:

- Conducting a biennial review and analysis of each member agency's legislative appropriations request (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 and recommending methods to prevent unnecessary parental relinquishment of custody of children;
- Prioritizing 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.

S.B. 717 (82-R) added a charge relating to information-sharing among agencies and the identification of technological methods for efficient and timely transfer of information among state agencies. Additionally, S.B. 44 (83-R) requires the Council to make recommendations to the executive commissioner regarding options for improving the system for serving families who relinquish, or are at risk of relinquishing, custody of a child solely to obtain mental health services.

The council's initial work has been focused on three priority areas: early childhood/early intervention, mental/behavioral health, and youth transitioning to adulthood. These priority areas were highlighted in the council's initial legislative report in January 2011, and they continue to be a focus of the council's work. The council's legislative report also included recommendations that the Legislature authorize the development of Regional Leadership Councils on Children and Families, and that the Legislature authorize the Council on Children and Families to

study and recommend an efficient organization of state-level children's councils, workgroups and committees.

Task Force for Children with Special Needs

The Task Force for Children with Special Needs was established by S.B. 1824 (81-R) 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 authority for people with intellectual disabilities. The purpose of the task force is to unite and direct a variety of key decision-makers to improve the coordination, quality, and efficiency for the delivery of services for children with chronic illnesses, intellectual and/or developmental disabilities, and/or mental illness.

In 2011, the task force created and released a five-year plan designed to improve service delivery for children from birth through age 21 who have special needs. The task force brought together policy-makers, agency leaders, disability advocates, consumers, and subject-matter experts to develop the original recommendations of a five-year plan, of which the task force directed implementation of the two highest priorities. Those include:

- Implementing a comprehensive web site for families and children with special needs, to be published in June 2015, and
- Developing a cross-agency implementation plan for a statewide crisis prevention/intervention protocol.

A biennial project status report will be issued in 2014.

Texas Nonprofit Council

The Texas Nonprofit Council was established by S.B. 993 (83-R) and is comprised of appointed representatives of nonprofit organizations and other entities that provide guidance on faith-based and community-based initiatives. The council also helps direct the work of the Interagency Coordinating Group (ICG), which is comprised of state agencies and led by the OneStar Foundation. In coordination with ICG, the council:

- Makes recommendations for improving contracting relationships between state agencies and faith- and community-based organizations,
- Develops best practices for cooperating and collaborating with faith- and community-based organizations,
- Identifies and addresses duplication of services provided by the state and faith- and community-based organizations, and
- Identifies and addresses gaps in state services that faith- and community-based organizations could fill.

4.4.2 Department of Aging and Disability Services

Aging Texas Well Advisory Committee

The Aging Texas Well Advisory Committee (ATWAC) is mandated by Executive Order RP-42 (2005) to provide advice to the Department of Aging and Disability Services (DADS) on the Aging Texas Well Plan and on the implementation of the Aging Texas Well initiative, and to make program and policy recommendations to DADS and to state leadership that are aimed at promoting state and community preparedness for the growing population of older Texans. ATWAC is comprised of members from various stakeholder organizations (including universities, advocacy groups, and service organizations) and many state agencies (including the Health and Human Services System (HHS) agencies, Texas Workforce Commission, and the Texas Higher Education Coordinating Board). Key committee activities include:

- Holding quarterly meetings to identify, learn about, educate members about, and discuss policy issues related to aging;
- Making recommendations to DADS and to state leadership;
- Providing advice regarding the rollout of the Aging Texas Well Community Assessment Toolkit, which facilitates community change to support aging in place;
- Providing technical assistance on research topics related to older adults in Texas and state agency readiness for the increasing older population;
- Sharing insights gained in the field by committee members; and
- Supporting other resource development as appropriate.

Texas Employment First Task Force

Senate Bill (S.B.) 1226 (83-R) establishes an Employment First policy, that “earning a living wage through competitive employment in the general workforce is the priority and preferred outcome for working-age individuals with disabilities who receive public benefits.” S.B. 1226 (83-R) also established the Texas Employment First Task Force “to promote competitive employment of individuals with disabilities and the expectation that individuals with disabilities are able to meet the same employment standards, responsibilities, and expectations as any other working-age adult.” The HHS System Executive Commissioner appointed the task force members, which include self-advocates, family members, advocates, providers of employment services, employers, and representatives of the five HHS agencies, the Texas Education Agency, and the Texas Workforce Commission.

The task force is charged with developing and submitting a biannual report to the Governor’s office and the Legislature containing recommendations for policy, procedure, and rule changes necessary to implement the Employment First policy. The first report is due September 1, 2014.

4.4.3 Department of Assistive and Rehabilitative Services

Rehabilitation Council of Texas

The legal basis for the Rehabilitation Council of Texas is Title I of the federal Rehabilitation Act of 1972, as amended by the Workforce Investment Act of 1998. The council is comprised of 15 members representing individuals with physical, cognitive, sensory, and mental disabilities; disability advocates; service providers; parents of individuals with disabilities; and rehabilitation counselors. Members are appointed by the Governor to three-year staggered terms. The council advises the Department of Assistive and Rehabilitative Services (DARS) on the policy, scope, and effectiveness of vocational rehabilitation services and eligibility requirements, and it works in partnership with DARS to develop the state plan for vocational rehabilitation.

Early Childhood Intervention Advisory Committee

The legal basis for the Early Childhood Intervention Advisory Committee is Part C of the federal Individuals with Disabilities Education Act. The committee is comprised of 24 members representing parents, service providers, a state legislator, advocates, state agencies, and the medical community. Committee members are appointed by the Governor to six-year staggered terms with terms of eight members expiring February 1 of each odd-numbered year. State agency representatives are nominated by their commissioners. The committee advises DARS Early Childhood Intervention on its operation of the statewide system for providing services to eligible children and families.

State Independent Living Council

The legal basis for the State Independent Living Council is Title VII of the federal Rehabilitation Act of 1973, as amended by the Workforce Investment Act of 1998. The council is comprised of 10 members, with the majority of the voting members being people with disabilities who are not employed by any state agency or center for independent living. Council members are appointed by the Governor for three-year terms. The council develops, approves, and implements the State Plan for Independent Living; leads, promotes, and advances the independent living philosophy; and, advocates for the rights of people with disabilities.

Interagency Council on Autism and Pervasive Developmental Disorders

The Texas Council on Autism and Pervasive Developmental Disorders was established by legislation in 1987 that added Chapter 114 to the Human Resources Code. Its mission is to advise and make recommendations to state agencies and the Legislature to ensure that the needs of persons of all ages with autism and other

pervasive developmental disorders and their families are addressed and that all available resources are coordinated to meet those needs.

The council is required to meet at least four times a year and produce an annual report each November. DARS provides administrative support to the council and manages the development of its annual reports and other council-initiated and sponsored projects.

The council is composed of seven public members, the majority of whom are family members of a person with autism, appointed by the governor with the advice and consent of the Texas Senate. A representative from each of the Health and Human Services System agencies and the Texas Education Agency serves as an ex officio member.

Coordination among agencies represented on the council has been integral to the development of several projects financed or sponsored by the council, including the website of the Texas Autism Research & Resource Center and a study to determine the costs and benefits of establishing a pilot program to provide services to adults with autism as required by House Bill 1574 (81-R).

The council maintains a website at www.texasautismcouncil.org.

Board for Evaluation of Interpreters

The legal basis for the Board of Interpreters is Texas Human Resources Code 81.007. The board is comprised of seven members, representing the public at large. Board members are appointed by the DARS Commissioner for three-year terms. The board advises the DARS Division for Rehabilitation Services, Office of Deaf and Hard of Hearing Services, on administering the interpreter certification program.

Elected Committee of Managers

The legal basis for the Elected Committee of Managers is the Randolph-Sheppard Act, 20 United States Code Section 107. The committee is comprised of 12 members, elected by blind managers participating in Business Enterprises of Texas (BET). Committee members serve two-year terms. The committee participates with DARS in major administrative decisions and in policy and program development affecting the overall administration of the state's vending facility program. The committee is not a governmental body and does not have decision making authority for the state's BET facility program.

4.4.4 Department of Family and Protective Services

Child Safety Review Committee

The Child Safety Review Committee (CSRC) was implemented in 1998–1999 during a review of high-risk and child death cases. The CSRC considers issues related to safety and prevention of fatalities that have statewide implications for policy, training, resource development, casework practice, and coordination with external entities. Issues are identified by child protective services (CPS) regional safety specialists through their review of CPS cases. The recommendations of the local Citizen Review Teams (CRTs) and the local Child Fatality Review Teams (CFRTs) are sent to the CSRC and are used in the CSRC recommendations. The CSRC meets the federal Child Abuse Prevention and Treatment Act requirements to review CRT recommendations for statewide implications. It also meets the legal requirement that the State Child Fatality Review Team perform the functions of a CRT (Texas Family Code Section 264.503).

The CSRC consists of representatives from the Department of Family and Protective Services (DFPS) and other agencies or groups, including the Texas Council on Family Violence, local CFRTs, the State Child Fatality Review Committee (discussed below), and Department of State Health Services. The CSRC meets quarterly, immediately before the State Child Fatality Review Committee meets, to review child fatality cases that were caused by abuse/neglect and had prior CPS history. CSRC recommendations have included:

- Recommending that safety plans are more concrete in terms of interventions planned to control safety factors and ensure the child's protection,
- Improving case documentation, and
- Providing enhanced training to staff on risk and history assessments.

Recommendations also involved strengthening training for the medical community about abuse and neglect. For fiscal year 2013, there were a total of 156 confirmed child fatalities as a result of abuse/neglect. Of these 156 child fatalities, the Child Safety Review Committee is in the process of reviewing the 72 cases that had prior CPS history. After this review, the committee will provide further recommendations as needed.

Texas Children's Justice Act Advisory Task Force

The Texas Children's Justice Act Advisory Task Force oversees the activities of the Children’s Justice Act, through a federal grant awarded to each state to develop, establish, and operate programs designed to improve the child-protection system. The task force is administered according to Section 107 of the Child Abuse Prevention and Treatment Act, as amended by the Keeping Children and Families Safe Act of 2003. The task force is a multidisciplinary group composed of professionals with knowledge of and experience with the child-protection and

criminal justice systems. Activities for which the task force provides oversight are in four primary areas:

- The handling of child abuse and neglect cases, particularly cases of child sexual abuse and exploitation, in a manner which limits additional trauma to the child victim;
- The handling of cases of suspected child abuse or neglect related fatalities;
- The investigation and prosecution of cases of child abuse and neglect, particularly child sexual abuse and exploitation; and
- The handling of cases involving children with disabilities or serious health-related problems who are the victims of abuse or neglect.

Every three years, the Task Force conducts a comprehensive review and evaluation of law, policy, and the handling of cases of child abuse and neglect and makes policy and training recommendations for systemic improvements.

Texas Family Violence Interagency Collaborative

The Texas Family Violence Interagency Collaborative is an interagency workgroup of staff from:

- The Health and Human Services Commission's Family Violence Program;
- DFPS's Adult Protective Services;
- DFPS's CPS; and
- The Texas Council on Family Violence (TCFV), which is the state domestic violence coalition.

This collaborative meets regularly to address sensitive issues related to provision of services to families where family violence and abuse of children or older people may be present. In 2012, an updated Memorandum of Understanding was finalized and implemented between DFPS and local domestic violence centers throughout Texas. In 2012, the collaborative also developed a best practice guide to provide guidance and information to DFPS staff and domestic violence shelter staff regarding how to collaborate to achieve safety from domestic violence.

From September 2011 through September 2013, CPS worked with stakeholders on the Senate Bill (S.B.) 434 (82-R) Taskforce to examine the connections of domestic violence and child abuse. Since the taskforce's expiration, CPS has continued to work collaboratively with stakeholders to implement the recommendations set forth in the taskforce's report. This work has included receiving technical assistance and input from Casey Family Programs, Texas stakeholders, and child welfare representatives from Washington, Oregon, and Massachusetts, to assist in the development of new Texas policies on family violence. It has also included collaborating with TCFV to select local family violence program representatives in all regions to serve on regional Citizen Review Teams which are focusing on the review

of CPS cases involving family violence for the 2013 and 2014 federal fiscal years. TCFV, with support from Texas Children's Justice Act funding, began in October 2013 to provide more extensive trainings on best practices for family violence programs and to provide technical assistance and support to the CPS Domestic Violence Family Based Safety Services pilot unit. Under this grant, TCFV will develop a fold-out resource card that will have information for adult survivors of family violence in the CPS system about their rights, responsibilities, and safety planning / domestic violence resources.

Early Childhood Health and Nutrition Interagency Council

The Early Childhood Health and Nutrition Interagency Council was established by S.B. 395 (81-R) to improve the health of Texas infants and children younger than age six. The council centralizes the efforts of Texas state agencies to combat childhood obesity and address malnutrition and undernourishment. Some key activities of the council include:

- Facilitating the consumption of breast milk in early childhood care settings,
- Aligning nutrition standards and meal patterns between the Child and Adult Care Food Program and DFPS Child Care Licensing for consistency and improved nutrition across all child care facilities preparing foods for infants and children younger than age six, and
- Providing statewide support to increase awareness of and access to nutrition assistance programs.

4.4.5 Department of State Health Services

Texas Collaborative for Healthy Mothers and Babies

With the inception of the Healthy Texas Babies (HTB) initiative in January 2011, the Department of State Health Services (DSHS) invited about 40 representatives from stakeholder groups in maternal and infant health to join an advisory body called the HTB Expert Panel. This group grew over the next two years, and the members worked on a variety of perinatal-focused projects in collaboration with staff from DSHS and other state agencies. As the group grew, interest in developing an independent perinatal quality collaborative increased. The panel investigated the possible forms this could take and looked at other successful models in Florida, Arizona, California, and Ohio.

In November 2013, DSHS held the inaugural meeting of the Texas Collaborative for Healthy Mothers and Babies, made up of more than 125 multi-disciplinary members, including many from the former HTB Expert Panel. Professional organizations, advocates, hospitals, the Health and Human Services Commission (HHSC), other Health and Human Service (HHS) System agencies, physicians, nurses, midwives,

public health departments, schools of public health, medical schools, insurance companies, and faith-based organizations are some of the areas represented. The collaborative, managed by DSHS, supports quality improvement projects in an effort to decrease infant mortality and prematurity in the state.

Statewide Health Coordinating Council

The Texas Health Planning and Development Act, Chapters 104 and 105 of the Texas Health and Safety Code, is the enabling statute for the Statewide Health Coordinating Council (SHCC). The broad purpose of the SHCC is to ensure healthcare services and facilities are available to all Texans through health planning activities. Based on these planning activities, the SHCC makes recommendations to the Governor and the Legislature through the Texas State Health Plan, submitted November 1 of each even-numbered year. The SHCC has statutory oversight of the Health Professions Resource Center and the Texas Center for Nursing Workforce Studies. It has two statutorily mandated advisory committees, the Texas Center for Nursing Workforce Studies Advisory Committee and the Health Information Technology Advisory Committee.

State Child Fatality Review Team Committee

The State Child Fatality Review Team Committee develops an understanding of the causes and incidences of child deaths and identifies procedures within the agencies represented on the committee to reduce the number of preventable child deaths. The committee promotes public awareness and makes recommendations to the Governor and Legislature for changes in law, policy, and practice to reduce the number of preventable child deaths. DSHS coordinates the committee, which includes members representing HHSC, the Department of Family and Protective Services, physicians, local law enforcement and emergency medical service agencies, and other agencies and stakeholders interested in the prevention of child deaths.

Governor’s EMS and Trauma Advisory Council

The mission of the Governor’s Emergency Medical Services (EMS) and Trauma Advisory Council (GETAC) is to promote, develop, and maintain a comprehensive EMS/trauma system that will meet the needs of all patients and that will raise the standards for community health care by implementing innovative techniques and systems for the delivery of emergency care for the entire population. The council is composed of Governor-appointed members representing EMS providers and educators, trauma facilities, physicians, and the public. GETAC advises DSHS on rules and standards for the system, assesses the need for EMS in rural areas of the state, and develops a strategic plan to refine education requirements for EMS workers’ certification and to develop EMS and trauma care systems.

Public Health Funding and Policy Committee

The Public Health Funding and Policy Committee was established in accordance with Senate Bill (S.B.) 969 (82-R). The committee is composed of representatives from health service regions (which are compatible with the 11 HHS System regions), local health departments, the local health authority community, and schools of public health. Its functions are to:

- Define core public health services,
- Evaluate delivery of public health services,
- Identify all funding available for use by local health entities, and
- Establish public health priorities for the state.

Preparedness Coordinating Council

The Preparedness Coordinating Council (PCC) is a multidisciplinary strategic review forum comprised of public health and medical emergency response stakeholders. The PCC provides guidance for coordination of state and local preparedness, response, recovery, and mitigation activities to carry out the DSHS public health and medical response mission. This council fulfills the requirements of Title 42 of the United States Code requiring an advisory committee to provide DSHS with advice on public health preparedness. It is the means by which DSHS obtains public comment on public health emergency programs and response systems.

Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Use Disorders

Formerly the Texas Mental Health Planning and Advisory Council, the Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Use Disorders (CAP) was created as a result of the federal requirement that states and territories engage in mental health planning to receive Mental Health Block Grant funds. The law further requires that stakeholders, including mental health consumers, their family members, and parents of children with mental health needs must be involved in planning efforts through membership in the CAP. In 2012, the council was expanded to include substance abuse consumers, advocates, and family members. The mission of the CAP is to serve as a planning and advisory group to ensure the provision of consumer- and family-centered services and supports for persons with mental and/or substance use disorders or serious emotional disturbance. CAP members monitor, review, evaluate, and make recommendations regarding the allocation and adequacy of mental and substance use disorder prevention, treatment, recovery, and resilience support services in Texas.

Drug Demand Reduction Advisory Committee

In 2001, the Legislature established the Drug Demand Reduction Advisory Committee (DDRAC) to develop a comprehensive statewide strategy and legislative recommendations that will reduce drug demand in Texas. The statute mandates that 16 state agencies participate in this effort, as well as 5 at-large members from different geographical areas within the state. Additionally, not later than January 15 of each odd-numbered year, the DDRAC presents a report to the Governor and the Legislature.

Local Authority Network Advisory Committee

The Local Authority Network Advisory Committee was established by the Legislature in 2007. The committee advises HHSC and DSHS on technical and administrative issues that directly affect local mental health authority responsibilities and submits quarterly reports to HHSC and DSHS on its activities and recommendations.

Texas Diabetes Council

Established by the Legislature in 1983, the Texas Diabetes Council works with private and public healthcare organizations to promote statewide diabetes prevention and awareness. The council addresses contemporary issues affecting health promotion services in the state, including professional and patient education, successful diabetes education strategies, personnel preparation and continuing education, state expenditures for treatment of chronic diseases, screening services, and public awareness.

Texas Council on Alzheimer’s Disease and Related Disorders

The Texas Council on Alzheimer’s Disease and Related Disorders was established by the Legislature in 1989 to advise and recommend needed actions for the benefit of persons with Alzheimer's disease and related disorders and their caregivers. The council also disseminates information on services and related activities; coordinates services and activities of state agencies, associations and other service providers; and encourages statewide coordinated research.

Texas School Health Advisory Committee

Established by the Legislature in 2005, the Texas School Health Advisory Committee provides active leadership in the identification and dissemination of school health best practices and resources for school policy makers.

Interagency Obesity Council

The Interagency Obesity Council was created by the Legislature in 2007 to monitor and evaluate obesity prevention efforts in Texas for both children and adults. The council serves to enhance communication and coordination of the critical health issue of obesity among state leaders and guide future planning around obesity prevention, health promotion, and improved nutrition.

Worksite Wellness Advisory Board

The Worksite Wellness Advisory Board was established by the Legislature in 2007 to advise DSHS, HHSC, and the DSHS Statewide Wellness Coordinator on specific worksite wellness issues, including developing funding and resources for worksite wellness programs, identifying food service vendors that successfully market healthy foods, and identifying best practices in the private sector for worksite wellness programs, features, and architecture for new state buildings.

Texas Council on Cardiovascular Disease and Stroke

Established by the Legislature in 1999, the Texas Council on Cardiovascular Disease and Stroke develops a plan to reduce the morbidity, mortality, economic burden of cardiovascular disease and stroke in Texas. The council conducts health education, public awareness, and community outreach; coordinates activities among agencies to improve access to treatment; develops a database of recommendations for treatment and care; and collects and analyzes information related to cardiovascular disease and stroke.

HIV Medication Advisory Committee

Established by the Legislature in 1992, and then re-established in 2011, the Human Immunodeficiency Virus (HIV) Medication Advisory Committee advises in the development of procedures and guidelines for the Texas HIV Medication Program (THMP). The committee reviews THMP's goals and aims, evaluates ongoing efforts, recommends short-range and long-range goals and objectives, and recommends medications for addition or deletion to the THMP formulary.

Health Care-Associated Infections and Preventable Adverse Events Advisory Panel

Health Care-Associated Infections (HAI) and Preventable Adverse Events (PAE) Advisory Panel was established by the Legislature in 2007 to make recommendations and guide implementation, development, maintenance, and evaluation of the HAI and PAE reporting systems.

Maternal Mortality and Morbidity Task Force

The Maternal Mortality and Morbidity Task Force was established in accordance with S.B. 495 (83-R) to study and review cases of pregnancy-related deaths and trends in severe maternal morbidity and make recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas.

Newborn Screening Advisory Committee

Established by the Legislature in 2011, the Newborn Screening Advisory Committee advises DSHS regarding strategic planning, policy, rules, and services related to newborn screening and additional newborn screening tests.

Promotor(a) or Community Health Worker Training and Certification Advisory Committee

Section 48.101 of the Texas Health and Safety Code established the Promotor(a) or Community Health Worker Training and Certification Advisory Committee. The committee advises DSHS and HHSC on the implementation of standards, guidelines, and requirements relating to the training and regulation of persons working as promotores or community health workers. The committee also reviews applications from training programs and sponsoring organizations, and it recommends certification to DSHS if program requirements are met.

4.5 Operational Coordination and Process Improvements

4.5.1 Historically Underutilized Businesses Plan

The Health and Human Services (HHS) System administers programs to encourage participation by historically underutilized businesses (HUBs) in all HHS System agencies' contracting and subcontracting. The HHS System's HUB Plan is included as Appendix G.

4.5.2 Cross-Agency Procurement and Contracting Initiatives

Sound contracting policy, procedures, management, monitoring, and training are the most effective and efficient ways to ensure appropriate oversight of contract management of the more than 33,882 contracts valued at more than $24 billion in 2013. The Health and Human Services Commission (HHSC) Procurement and Contracting Services (PCS) provides guidance on and coordination of these activities.

A Contract Management Workgroup was formed in June 2013 of representatives from the Health and Human Services (HHS) System agencies to develop comprehensive contract management instructions in the HHS Contract Manual Guide. This manual documents standard policies and practices necessary to manage all HHS contracts effectively. To ensure its uniform application, HHSC mandates the manual's use throughout the HHS System.

PCS will work on several issues during the strategic planning period:

- **Continuing to Explore Technology—**Investigating opportunities to use technology to streamline procurement and contracting processes, in particular the solicitation process and a comprehensive automated enterprise contract database;
- **Electronic File Management System—**Researching opportunities for maintaining files electronically; and
- **Contract Training and Certification—**Developing a contract management training program in coordination with the Comptroller of Public Accounts. Senate Bill 1681 (83-R) requires that all state agency contract managers are certified by September 1, 2015.

Each HHS System agency supports these initiatives and will be working to implement the work plan items. There may be slight differences in the way each agency develops internal procedures to implement them.

4.5.3 Telework, Mobile Work, and Alternative Officing

The Health and Human Services Commission (HHSC) System Support Services (SSS) has been actively promoting the use of telework and mobile work across the Health and Human Services (HHS) System to enhance services and provide efficiencies. The foundation for these activities rests upon:

- The idea that work is what one does, not where one does it;

- The experience of other organizations who have successfully initiated telework and mobile work; and
- Successful efforts in the HHS System.

SSS ultimately expects to provide working conditions that enhance recruitment and retention, increase productivity and efficiencies by providing efficient tools for our mobile workers, and reduce office space needs across the system.

The HHS System Telework, Mobile Work, and Alternative Officing Project was established to assess the use of telework and mobile work in the HHS System and the potential for strategic expansion, which could reduce the need for leased space across the state. In the Fall of 2011, SSS worked collaboratively with all HHS System agencies to conduct this review and identify opportunities for development and/or expansion of telework and/or mobile work. Telework policy, forms, and approval processes were standardized across HHS System agencies, with each agency retaining latitude for more specific policy and processes as appropriate. A liaison was established at each agency to take responsibility for tracking alternative officing and monitoring related efforts.

Telework is expanding across the HHS System, with variations in the number of days teleworked by employees. Telework appears to be a good model for call centers. Both the HHSC Office of Social Services' Customer Care Centers and the Department of Family and Protective Services (DFPS) Statewide Intake Center have adopted a telework model, and a significant number of their staff now works from home full time.

Because the telework approval process is paper-based, it requires manual reporting and analysis of data, making it difficult to assess its usage and utility statewide or by region. SSS worked with the HHS System's telework coordinators to develop a plan for automating the approval process in the State's Centralized Accounting and Payroll/Personnel System (CAPPS); it is has not been determined when this upgrade would fit in to the other scheduled upgrades for CAPPS. Automation will support more comprehensive analysis and efficient tracking of the effects of teleworkers.

There is much potential to be gained in providing automation for mobile workers across the HHS agencies. DFPS is leading the way in outfitting their field staff with technology to increase performance and efficiency.

In early 2013, SSS worked to survey HHS System agencies to identify mobile work positions which could potentially benefit from technology that allows more timely decision-making and reduces the need for dedicated office space. Close to 10,000 positions were identified. SSS is now surveying the HHS System agencies to determine the technological needs of these positions to support their performance in the field and untether them from the need for dedicated office space. Programs will be selected to pilot the use of technology for demonstration purposes and to provide

an initial estimate of costs involved in providing such automation to mobile workers across the HHS System that do not already have the technology.

Finally, as HHS System agencies begin to use telework and mobile work more widely, a System-wide workgroup is currently considering how agencies can reduce their office footprint using telework, mobile work, and other strategies.

4.5.4 Succession Planning and Job Rotations Initiatives

In October 2012, the Health and Human Services (HHS) System established a work group to collaborate with a human resources consulting group to develop a succession plan for the HHS System agencies. This enterprise-wide work group is continuing the effort begun with the consulting company. The work group is developing tools for identifying leadership and critically important technical areas where staff turnover may occur, and where the skills and competencies necessary for success may be compromised.

Parallel with the succession planning project is the development of a job rotation demonstration project. Job rotation involves the proactive and systematic movement of selected employees either vertically or laterally into targeted positions within an organization. Job rotation is an established and proven approach to professional development. A demonstration project underway within the Health and Human Services Commission to test out various ways in which staff can move temporarily to other areas for the purposes of developing and expanding their knowledge, skills, and abilities while also giving the agency an additional resource to perform essential job duties, if necessary.

4.5.5 Leadership Development

Effective leadership is vital to the success of any organization. Developing leadership at all levels of the Health and Human Services (HHS) System ensures a fundamental understanding of how the HHS System agencies interact and may create strategic ideas for further collaboration. Leadership development also ensures that employees have the necessary competencies to fill critical positions as they move into positions vacated by other employees. The Health and Human Services Commission has established a Leadership Development Program that provides various opportunities for employees at different levels of development to increase skills and gain a better understanding of the HHS System. Staff will continue to assess the needs of the HHS System and the efficacy of current training course offerings, to ensure the provision of applicable content and maximized transfer of meaningful knowledge. One example is the HHS Executive Leadership Academy (ELA), which engages selected staff in an intensive program of training,

experiential activities, professional mentoring, and action learning. The ELA provides unique access to executive leadership across the HHS agencies and gives participants the opportunity to study the HHS System from across all five agencies.

4.5.6 Survey of Employee Engagement

The Survey of Employee Engagement, designed by and conducted under contract with the University of Texas School of Social Work, offers participating agencies the opportunity to observe agency employees' perceptions and opinions of their employment experience. Understanding how employees perceive various aspects of the workplace is critical to identifying and successfully implementing needed organizational changes. Data gathered over time provide additional insight into trends in employee perceptions. The summary of the survey responses may be found in Appendix F, highlighting survey results for the Health and Human Services System.

4.5.7 Structured Approach to Risk Management

A structured approach to business risk management helps organizations comply with government requirements and achieve their goals and objectives. Data-driven performance metrics provide information managers can use to improve operations, establish priorities, and assess funding needs. In March 2014, the Health and Human Services Commission (HHSC) Executive Commissioner created the Risk and Compliance Management division to implement best practices based on integrated frameworks for internal control and enterprise risk management. This new division will help Health and Human Services (HHS) System agencies identify key risks and management controls, assess the effectiveness of those controls, and develop data-driven performance measures so management can direct targeted action when needed.

Implementation will be phased in over the next three to five years, beginning by addressing risks related to compliance with federal and state laws and regulations within HHSC business areas. The structured approach will be expanded to address risks that could prevent achievement of business goals and objectives, and to include the other HHS System agencies and agency contractors.

Chapter 5

Health and Human Services Commission Strategic Plan 2015–2019

5.1 Overview

The Health and Human Services Commission (HHSC) was created in 1992 to coordinate and improve the delivery of health and human services across Texas. House Bill 2292 (78-R), charged HHSC with overseeing the transformation of the delivery of health and human services. Thus, HHSC has responsibilities as a leadership, operational, and oversight agency. The agency is accountable to Texans for ensuring that the consolidated Health and Human Services (HHS) System agencies provide quality services as efficiently and effectively as possible.

Under this consolidated structure, the HHS System consists of five agencies:

- HHSC,
- The Department of Aging and Disability Services,
- The Department of Assistive and Rehabilitative Services,
- The Department of Family and Protective Services, and
- The Department of State Health Services.

The remainder of this chapter is arranged as follows:

- Mission,
- External Challenges and Opportunities,
- Internal Challenges and Opportunities, and
- Agency Goals: Target Populations and Services Descriptions.

5.2 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 of funds.

5.3 External Challenges and Opportunities

To serve clients as effectively and efficiently as possible, HHSC tracks external trends, such as population growth and economic changes, and adapts business processes accordingly. The agency also works to implement new state and federal policy direction and requirements. The challenges and opportunities that are most significant at this time are described here.

5.3.1 Promoting Health Quality and Ensuring Cost-Effectiveness

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

- Emphasize health promotion, disease prevention, early intervention, and primary care, in a quality-oriented, electronically enabled, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Ensure all programs and initiatives recognize and address health disparities and disproportionality to improve outcomes.
- Continue improving the availability of timely and accurate information to support data-driven decision-making, and invest in systems to leverage the state's health information exchange network where appropriate.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

With guidance from Texas policy leaders and national experts, HHSC works to ensure the quality of health care within funds allocated by the state. The overall challenge for HHSC is to keep the cost of care as affordable as possible, meet

quality standards, and ensure enough physicians, hospitals, and providers are available to treat the growing Medicaid population.

Medicaid costs are the primary budget driver for HHSC, with client services costs in 2014 expected to be just under $26 billion in federal and state funds. To improve outcomes and cost-effectiveness, new approaches are being developed based on recent trends, rising caseloads, and the rising care costs.

In state fiscal year (FY) 2013, the average monthly number of Medicaid recipients was 3.65 million, almost unchanged compared to FY 2012. During that same period, the state's total population grew by about 6 percent.

Costs of care are rising, especially with inpatient hospital services, typically needed by people with multiple health conditions. This group of people is growing at a faster rate than the groups of lower-cost clients. Additional cost drivers for the next several years will include rising health care needs of many Medicaid clients, as people live longer and as new clients may be added to the caseloads by federal Medicaid changes.

Given these circumstances, HHSC is working on several approaches to improve Medicaid quality and cost-effectiveness.

In July 2011, HHSC filed an application for a waiver of certain federal Medicaid requirements under Section 1115 of the Social Security Act, and the United States (U.S.) Centers for Medicare & Medicaid Services (CMS) approved HHSC's application in December 2011. The waiver makes two major changes:

- Allowing statewide expansion of managed care while preserving hospital supplemental payments under a new methodology, and
- Providing incentives for delivery system improvements.

HHSC is also adopting a wide variety of accountability structures to decrease the incidence and associated costs of preventable health conditions.

These and other efforts are described below.

Hospital Payment System Reform—Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

Discussion

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver that allows the state to expand Medicaid managed care, including pharmacy and dental services and additional inpatient care, while preserving federal hospital funding historically received as Upper Payment Limit (UPL) payments. UPL

payments were supplemental payments making up the difference between what Medicaid pays for a service and what Medicare would pay for the same service. The 1115 Transformation Waiver provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds.

Funding Pools

Replacing the UPL payment methodology are two funding pools, one based on costs and the other based on performance outcomes.

- **Uncompensated Care (UC)** payments are cost-based and will help offset the costs of uncompensated care provided by hospitals and other providers.
- **Delivery System Reform Incentive Payment (DSRIP)** funding provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers will develop and implement programs, strategies, and investments to enhance:
  - Access to health care services,
  - Quality of health care and health systems,
  - Cost-effectiveness of services and health systems, and
  - Health of the patients and families served.

Regional Healthcare Partnerships

Under the 1115 Transformation Waiver, eligibility to receive UC or DSRIP payments requires participation in one of 20 Regional Healthcare Partnerships (RHPs), which reflect existing delivery systems and geographic proximity. The RHPs include public hospitals, public health care districts, health providers, and/or other stakeholders in a given region. The activities of each RHP are coordinated by an anchoring entity, which is a public hospital or other local governmental entity with the authority to make intergovernmental transfers (IGTs). An anchoring entity can be a hospital district, a hospital authority, a state university with a medical school or health science center, or a county.

Various kinds of providers and governmental entities will be key participants in the projects.

- **Intergovernmental transfer entities** are public hospitals or other governmental entities that may contribute public funds to draw down federal matching funds under the waiver. IGT entities select DSRIP projects from the RHP Planning Protocol list of projects, determine estimated funding for each project, identify performing providers to implement those projects, and provide funding.
- **Performing providers**, including hospitals, community mental health centers, local health departments, and physician practice plans, may receive waiver incentive payments for completing project objectives detailed in the RHP plan. Certain entities, such as public hospitals, may serve as both an IGT entity and a performing provider.

The RHPs outlined projects and estimated funding levels in plans for HHSC approval early in FY 2013. Only projects selected from the RHP Planning Protocol and included in an RHP plan approved by HHSC and CMS qualified for DSRIP payments.

Funding Under the Waiver

Federal funds available under both UC and DSRIP pools require local or state IGT funding, which is public funding from public hospitals or other governmental entities that may be used to draw down federal matching funds under the waiver. IGT funds draw down approximately 60 percent federal matching funds. For example, a public hospital with $40 million in IGT funds can receive approximately $60 million in federal matching funds, for a total payment of $100 million under UC or DSRIP.

In Demonstration Year (DY) 1, $4.2 billion (all funds) was available for UC and DSRIP, and in all other years, the two pools could consist of up to $6.2 billion all funds, for a potential total of $29 billion, all funds, over the five years of the waiver. In DY 1, most of the waiver funds were directed toward UC, but by DY 5, funds for UC and DSRIP are capped at equal levels.

DSRIP Projects

Funds received from the DSRIP pool cannot be used to maintain existing projects or continue services already provided. DSRIP funds can be used to enhance a project or expand services provided, if such a project is outlined in a plan approved by HHSC and CMS.

Potential projects are divided into four categories.

- **Category 1: Infrastructure Development** lays the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
- **Category 2: Program Innovation and Redesign** include the piloting, testing, and replicating of innovative care models, such as telemedicine, patient-centered medical home, and innovations in health information and disease prevention.
- **Category 3: Quality Improvements** include improvements in care that can be achieved within four years and outcome reporting on items such as potentially preventable hospital admissions and readmissions.
- **Category 4: Population-Based Improvements** include a series of reporting measures for a hospital to demonstrate the community-wide impact of delivery system reform investments that were made. Reporting includes data related to potentially preventable admissions, readmissions, and complications; patient-centered health care; and emergency department utilization.

Planned Actions

Additional information and waiver updates can be found at the Medicaid Transformation Waiver (http://www.hhsc.state.tx.us/1115-waiver.shtml) page on the HHSC website.

Using Managed Care to Ensure Continuous Improvement in Quality and Cost-Effectiveness

Discussion

In Texas and nationally, the Medicaid program and the Children's Health Insurance Program (CHIP) have increasingly turned to managed care systems to deliver more efficient services. The traditional Medicaid payment system, known as fee-for-service, pays health care providers a fee for each unit of service they provide. This system can result in extra procedures and other issues that are not helpful for the client and incur unnecessary costs. In a managed care program, a managed care organization (MCO) is paid a capped (or capitated) rate for each client enrolled. Each MCO has the financial incentive to provide efficient health care delivery. HHSC has continued to expand Medicaid managed care in Texas. As of August 2013, 2,965,000 clients, or 81 percent of the total number of people enrolled in Medicaid, were in managed care.

HHSC continually monitors whether MCOs are succeeding in their work. Savings found by moving from a traditional Medicaid model to an MCO system have been particularly robust in the first few years of the change. For example, Medicaid clients learn how to use a medical home where primary care is coordinated by a primary care provider, rather than going to an emergency room each time health care is needed.

To help contain costs, HHSC monitors a variety of costs and factors that determine provider payment. HHSC researches more than 10,000 different prices for health care services, compares these prices to the private sector and other Medicaid programs, and identifies possible changes that will lower expenses. To identify wasteful spending in managed care, HHSC monitors how MCOs are spending paid premiums. HHSC also studies provider procedure patterns to identify areas where changes can be made to encourage the use of less expensive procedures when outcomes can be equally successful.

Planned Actions

Managed Care Organization and Dental Pay-for-Quality

The Pay-for-Quality Program uses an incremental improvement approach that provides financial incentives and disincentives to managed care organizations based on year-to-year incremental improvement on pre-specified quality goals. The quality-of-care measures used in this initiative are a combination of process and

outcome measures which include certain potentially preventable events and other measures specific to the program's enrolled populations. The Pay-for-Quality Program includes an at-risk pool that is four percent of the managed care organization capitation rate. In the Pay-for-Quality Program, points are assigned to each plan based on incremental performance on each quality measure, with positive points assigned for year-to-year improvements over a minimum baseline. Negative points are assigned for most year-to-year declines, with the exception of modest decreases of plans whose performance is already performing within a specified range of the attainment goal rate.

The 2014 Dental Pay-for-Quality Program includes a two percent at-risk pool. Points are assigned to each plan based on its incremental performance on each quality measure, with positive points assigned for year-to-year improvements over the minimum baseline and negative points assigned for most year-to-year declines.

Hospitals' and MCOs' Accountability for Potentially Preventable Events

HHSC holds MCOs and hospitals financially accountable for low performance on potentially preventable events, including potentially preventable complications (PPCs) and potentially preventable readmissions (PPRs). Adjustments are made to fee-for-service hospital inpatient claims based on performance on these measures. In managed care, the MCO capitation rates are adjusted to reflect the expected PPR and PPC reductions, based on historical hospital claims at the impacted facilities.

Exploring Other States' Value-Based Purchasing/Payment Reform Efforts

Senate Bill (S.B.) 7 (83-R) requires HHSC to explore different premium rate-setting strategies that encourage provider payment reform. Part of the project will involve reviewing innovative payment strategies used by other states.

HHSC engaged a consultant to evaluate payment reform and value-based purchasing strategies used by other states. The states included in the analysis are California, Florida, Kansas, Minnesota, Tennessee, Pennsylvania, and Oregon. The consultant is interviewing each state's Medicaid leadership on the details of their program, cost efficiency measures employed, quality measures used, and outcomes achieved. The consultant is also assessing HHSC's current approach, to determine whether there are different approaches that HHSC can adopt to promote more efficient service delivery and provider practices.

MCO Contract Provision Regarding MCO-Provider Value-Based Purchasing

Fee-for-service payment models are generally seen by health care experts to incentivize volume and not quality. The state's contract with MCOs and Dental Maintenance Organizations requires them to develop alternate payment structures between the health plans and providers. The goal is to put more focus on quality and not volume. Each MCO must submit to HHSC an annual plan for expansion of alternative payment structures with its providers that encourage innovation and

collaboration and that increase quality and efficiency. The plans must include mechanisms by which the MCO will provide incentive payments to hospitals, physicians, and other providers for quality of care. Plans must include:

- Quality metrics required for incentives,
- Provider recruitment strategies, and
- A proposed incentive payment structure, shared savings, or both.

HHSC is evaluating each plan and providing feedback to the MCOs. Plan approval is based on the number of providers targeted by the MCO, the diversity of selected providers, geographic representation of providers, methodology of the shared savings plan, a data sharing strategy with providers, and other factors. HHSC will evaluate the MCOs on their execution of the approved plans. Each year, the annual plan must show a measurable increase (percentage of capitation, numbers of providers, or members) from the previous year.

MCO Performance Improvement Projects

HHSC requires each Medicaid and CHIP MCO to complete annual performance improvement projects that are designed to improve the quality of care. These projects require the completion of a root cause analysis of need areas identified by the External Quality Review Organization (EQRO) based on past health plan performance, member surveys, and administrative and encounter files. The EQRO is federally required for external quality review of Texas Medicaid Managed Care and CHIP. The Institute for Child Health Policy has been the EQRO for HHSC since 2002. HHSC selects two of these goals, which become health plan projects that target specific areas for improvement. The projects are precise and measurable, and they reflect topics that present significant opportunities for performance improvement for each. When undertaking a performance improvement project, MCOs are required to follow the 10-step Centers for Medicare & Medicaid Services (CMS) protocol published in the CMS EQRO Protocols. Each health plan is scored based on the outcome of its performance improvement project.

Beginning in 2015, MCOs will be required to conduct one of their two performance improvement projects collaboratively with other health plans in their region.

Quality Website/Public Reporting

To communicate better with stakeholders about Texas efforts on the numerous quality initiatives that are underway or in development, HHSC is launching a website dedicated to describing and sharing information and data related to these initiatives. As public reporting is a key component of an overall quality strategy, a central feature of this website is a more accessible and robust public reporting process.

MCO Report Cards

HHSC and the state's EQRO developed annual report cards describing MCO performance on specific measures of quality of care and patient satisfaction. The report cards are developed for each program and managed care service area so enrollees and recipients can compare scores easily. Report cards are included in the enrollment packets to help members make informed selections of MCOs.

Data-Sharing to Reduce Preterm Births

S.B. 7 (83-R) requires HHSC and other HHS enterprise agencies to share certain data to facilitate patient care coordination, quality improvement, and cost savings. HHSC and the Department of State Health Services (DSHS) are currently engaged in an initiative designed to provide MCOs with information to help them more efficiently target women of childbearing age who have had a previous pre-term birth. HHSC Medicaid eligibility files are matched with the DSHS birth records database each month to link enrollee data with information related to prior preterm births and other complications during delivery. This compiled information is shared with MCOs, which can then target their enrollees for possible intervention and treatment to decrease risk of a subsequent preterm birth.

MCO Quality-Based Enrollment Incentive

As directed by S.B. 7 (83-R), HHSC is exploring incentive programs that would assign more Medicaid members to MCOs with better performance. This process may be based on MCO quality of care and scores on performance improvement projects or other outcome measures, such as potentially preventable events. HHSC's initial step is to evaluate the effects of the health plan report cards to determine what outcomes this initiative has on the number of people actively selecting health plans based on performance.

Long-Term Services and Supports Performance Measures

The STAR+PLUS home and community-based services program provides assistance with activities of daily living to allow members to remain in the most community-integrated setting available. It includes services available to all STAR+PLUS members as well as those services that would otherwise be available only to STAR+PLUS members from the following groups:

- Adults ages 65 and older who meet the criteria for nursing facility level of care,
- Adults ages 21 and older with physical disabilities who meet the criteria for nursing facility level of care, and
- Adults ages 21 and older who are eligible for Supplemental Security Income (SSI) and SSI-related Medicaid and meet the criteria for nursing facility level of care.

In the fall of 2013, HHSC convened a workgroup consisting of external stakeholders and representatives from the EQRO to develop a comprehensive set of performance measures that will provide data so HHSC can evaluate the quality of home and community-based services long-term services and supports provided through Medicaid managed care. This process is ongoing.

Nursing Facility Performance Measures

S.B. 7 (83-R) requires HHSC to include nursing facility services in managed care. HHSC, together with the Department of Aging and Disability Services, has developed a draft set of performance measures that will gauge quality of care in the nursing facility environment and that will incentivize managed care organizations to ensure a high quality of care. The draft measures are undergoing stakeholder review. Implementation of data collection will coincide with this implementation.

Medicaid Managed Care Expansion

Discussion

S.B. 7 (83-R) directs HHSC to continue several expansions of Medicaid managed care and to develop a performance-based payment system that rewards outcomes and enhances efficiencies.

Planned Actions

Managed care expansion plans include the following programs and initiatives.

- **STAR+PLUS—**Managed care program that provides integrated acute and long-term care services and supports to people with disabilities and people ages 65 and older.
  - Program is scheduled to expand statewide on September 1, 2014.
  - Adults with intellectual and developmental disabilities will receive basic health services through a STAR+PLUS health plan on September 1, 2014, except those who reside in State Supported Living Centers.
  - Children and youth younger than age 21 receiving SSI or SSI-related benefits may choose to enroll in STAR+PLUS.
  - People living in nursing facilities will receive full Medicaid coverage through a STAR+PLUS health plan on March 1, 2015.
- **STAR Kids—**The first Medicaid managed care program specifically serving youth and children who are enrolled in disability-related Medicaid.
  - Program is scheduled to start September 1, 2016.
  - For children and youth younger than age 21 who have Medicaid through Social Security Insurance or 1915(c) waiver programs.
  - Provides full Medicaid services (both basic health services and long-term services and supports) for people in Medically Dependent Children Program.

- Provides basic health services for children and youth in other 1915(c) waiver programs.
- Includes development of a service plan for each member and service coordination.

- **Pilot Programs and Other Initiatives—**Initiatives being pursued for future years.
  - Redesign mental health rehabilitation and mental health targeted case management services, currently provided by DSHS through local mental health authorities, to incorporate these services into STAR and STAR+PLUS beginning September 1, 2014, to better integrate physical and behavioral health care for clients.
  - Basic attendant care and habilitation services to increase or maintain the skills of a member and emergency response services (also referred to as Community First Choice).
  - Complete the redesign of the medical transportation program which began with the deployment of full risk transportation brokers in two metropolitan areas: Dallas and Houston. Managed Transportation Organizations will serve clients in the remainder of the state beginning September 1, 2014.

Federal Health Care Changes that Increase Caseloads and Costs of Medicaid/CHIP

Discussion

In March 2010, the federal Affordable Care Act (ACA) was signed into law, making significant changes to health care coverage across the nation. The majority of changes required of the state, some of which are identified below, have already been implemented, including Medicaid benefit changes, eligibility changes, pharmacy changes, changes to federal matching funds, and program integrity provisions. Texas agencies continue to implement the requirements.

The material below focuses on the requirements that began to affect Medicaid and CHIP on January 1, 2014. Texas will experience caseload growth in numbers of newly eligible individuals and individuals who are currently eligible but not enrolled in Medicaid or CHIP. As of June 2014, HHSC has seen growth in our combined Medicaid and CHIP caseloads, and the agency is analyzing the impact of these changes to determine the magnitude of expected growth and to categorize the growth in caseload appropriately.

Changes in Eligibility Criteria

Federal law requires states to expand Medicaid to some populations effective January 1, 2014.

Mandatory Medicaid Expansion for Children Ages 6 to 18

Federal law expands Medicaid to children ages 6 to 18 who are in families with incomes above 100 percent up to 133 percent of the federal poverty level (FPL). The law moves these children from CHIP to Medicaid.

Mandatory Medicaid Expansion for Former Foster Care Youth

The federal law expands Medicaid to former foster care youth who were enrolled in Medicaid while in foster care and were in state care on their 18th birthday or up to their 21st birthday. These youth are eligible for Medicaid, regardless of their income, through age 25.

Financial Eligibility

Effective January 1, 2014, federal law requires states to determine financial eligibility for most individuals in Medicaid and CHIP based on the modified adjusted gross income (MAGI) methodology. The MAGI methodology uses federal income tax rules for determining income and household composition. The federal law applies a five percentage point income disregard to individuals who are subject to the MAGI methodology.

The MAGI methodology applies to the Medicaid eligibility groups for children, pregnant women, and parents and caretakers. Federal law provides exceptions to the use of the MAGI methodology and to the elimination of assets tests and income disregards. In Texas, the exceptions primarily apply to emergency Medicaid, foster care children, medically needy, individuals receiving Supplemental Security Income, and Medicaid programs for people ages 65 and over and those with disabilities.

Also effective January 1, 2014, federal law prohibits the use of assets tests and most income disregards for Medicaid and CHIP eligibility determinations. Previously, Texas applied assets tests and income disregards to most Medicaid programs, and the state applied an assets test to children above 150 percent of the FPL and income disregards to determine CHIP eligibility.

Income Limits for Children's Eligibility

As a result of changes to the income limits, some children in CHIP will be eligible for and moved to Medicaid. The CHIP income limit remains at 200 percent of the FPL. Children are first screened for Medicaid, and if the family's income is above Medicaid limits, they are then screened for CHIP eligibility.

HHSC estimates that approximately 280,000 children will move from CHIP to Medicaid by August 31, 2015. This change is expected to cost the state about $47 million due to the differences between Medicaid and CHIP. Medicaid has no enrollment fees or co-pays, but covers more services than CHIP, including transportation to and from medical appointments and expanded dental coverage.

In the event that the federally designated CHIP funding allotment to the State is insufficient to cover all children eligible for CHIP, federal law requires states to ensure that these children, who are not eligible for Medicaid, receive coverage through the federally facilitated marketplace (FFM) after September 30, 2015. In addition, federal law requires the Secretary of the U.S. Department of Health and Human Services, no later than April 1, 2015, to certify that the plans in the FFM that offer services for children have benefit and cost-sharing levels comparable to CHIP.

Individual Mandate

The federal law includes a mandate that everyone obtain health insurance. Some lower-income Texans who are not insured will seek Medicaid coverage to satisfy the mandate, and caseloads will grow. In March 2014, the federal government issued guidance delaying the implementation of the individual mandate until 2016.

Texas Declines Optional Eligibility Expansion

On June 28, 2012, the U.S. Supreme Court declared unconstitutional the provision of the new federal law that required all states to expand Medicaid to cover certain low-income populations. The Court determined that the Medicaid expansion could not be required of states as a condition of receiving federal funding for their existing Medicaid programs, making it essentially optional for states. Texas is not currently pursuing a Medicaid expansion.

Changes in Processes for Determining Eligibility

Applications & Renewals

- States must use a single, streamlined application form for Medicaid, CHIP, and other health care options available through the FFM.
- For MAGI groups, states must redetermine eligibility every 12 months and no more frequently than once every 12 months except when a change in circumstance is received by the state that may affect an individual's eligibility.
- States must use an administrative or passive eligibility renewal process for MAGI groups. To the extent possible, states must use available information to make eligibility redeterminations without requesting information or an application from clients.

Verifications

- States must use electronic verifications to the extent possible.
- States must accept self-attestation of all information for Medicaid and CHIP (except for citizenship and immigration status), such as household composition, non-financial eligibility status, pregnancy, and residency.

Performance Standards

- States must establish timelines and performance standards for determining eligibility promptly, with 45 days as the maximum limit for determining Medicaid eligibility for clients without disabilities.
- The federal government has indicated “real-time” eligibility determinations are possible in most cases.

Coordinating Medicaid, CHIP, and Exchange Eligibility Determinations

- State Medicaid and CHIP programs must establish an electronic interface with the FFM to coordinate eligibility determinations. Applications submitted through the FFM that are determined to be potentially eligible for Medicaid or CHIP in Texas are electronically transferred to HHSC’s eligibility system. If an individual applies through the state and is determined ineligible for state Medicaid and CHIP programs, the applicant’s information is returned electronically to the FFM.
- States had the option of delegating eligibility determinations to the FFM. Texas did not elect this option; therefore, HHSC eligibility staff determines eligibility for Medicaid and CHIP for the accounts transferred to the state from the FFM.

Changes to Pharmacy Benefits

The Omnibus Budget Reconciliation Act (OBRA) of 1990 established the federal Medicaid drug rebate program. OBRA requires drug manufacturers, as a condition of participation in the Medicaid program, to pay rebates that are shared by the federal and state governments for covered outpatient drugs that are dispensed to Medicaid patients. In exchange, state Medicaid programs are required to cover all of a manufacturer’s contracted drug products.

Effective January 1, 2010, federal law increased the minimum federal rebate percentages that drug manufacturers are required to pay for participation in the Medicaid program and specified that all of the revenues collected due to these changes will be paid to the federal government. Federal law enables states to collect rebates for drugs dispensed through managed care organizations. With the March 2012 managed care expansion in Texas, pharmacy benefits were carved into the Medicaid managed care delivery system.

Increased Provider Rates

The ACA directs states to increase Medicaid reimbursement to certain primary care providers for specific procedure codes, classified as primary care services in the federal law, at the Medicare reimbursement rate in calendar years 2013 and 2014. Under the law, providers eligible for the increase must submit an attestation to certify that they qualify for the increase.

States receive 100 percent federal match for the difference in the July 1, 2009, Medicaid rates and 2013–2014 Medicare rates. Because Texas implemented rate reductions in February 2011, the state will incur some cost for the difference in the 2009 rate and currently effective rate. The federal match rate of 100 percent is only available for the difference in the state's July 1, 2009 rate, increased to the Medicare rate effective in 2013 and 2014.

Texas began issuing interim supplemental payments of the first and second quarter for 2013 to managed care providers in February 2014 and continues to work to fully implement the rate increase. Payments will be made retroactive to January 2013 for all eligible providers.

Planned Actions

Re-Enrollment of Medicaid and CHIP Providers

HHSC continues to work to implement program integrity provisions related to the re-enrollment of Medicaid and CHIP providers. Federal law requires providers to re-enroll in Medicaid, Medicare, and CHIP at a minimum of every five years. HHSC implemented programmatic changes in January 2013 to comply with federal changes to provider enrollment, and the agency continues to work on re-enrolling providers who were enrolled in Medicaid and CHIP prior to January 2013.

Rider 86: Transitional Medicaid DSH and Related Payments

HHSC will adopt new methodologies for the Disproportionate Share Hospital (DSH) and Uncompensated Care (UC) programs in September 2014 to meet the Rider 86 requirements to access $160 million in general revenue funds for 2014 DSH. HHSC will continue working with stakeholders through FY 2015 to ensure continued compliance with Rider 86 requirements to access $140 million in general revenue for FY 2015 DSH, and beyond FY 2015 to ensure the continued functionality of the DSH and UC supplemental payment programs.

Federal Methodologies Reducing Disproportionate Share Hospital Funding

Under federal law, the Secretary of the U.S. Department of Health and Human Services is required to develop a methodology that will reduce disproportionate share hospital payments by $17.6 billion between 2016 and 2020. HHSC will address the changes in this methodology in future years.

5.3.2 Meeting Increased Demand for Eligibility Determination Using Innovation and Technology

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

- Emphasize health promotion, disease prevention, early intervention, and primary care, in a quality-oriented, electronically enabled, cost-effective system of care, improving outcomes for long-term public health and well-being.

Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.

- Ensure policies and services encourage responsibility, promote self-service options, and improve access to competitive employment for all Texans.
- Assist older Texans and those with disabilities to gain, maintain, and enhance their ability to live independently.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Discussion

HHSC continues to implement improvements to its eligibility system to reduce the demand on eligibility staff resources, ensure efficiency with taxpayer resources, and improve client self-service options for accessing information about their cases. Agency initiatives are underway to leverage technology and business process improvements to meet the forecasted growth in client caseload over the next several years.

To meet growing caseloads within existing resources, one of HHSC's key initiatives is to expand and improve client access to self-service options available through YourTexasBenefits.com. Increased use of self-service options helps manage workload by reducing data entry, client traffic, and calls to eligibility offices. This allows staff to focus on their core function of making accurate and timely eligibility decisions. These efforts have proved advantageous for the agency, as the number of web-based applications completed increased by over 400 percent between 2010 and 2013.

Figure 5.1
Applications Submitted by Clients through YourTexasBenefits.com, Calendar Years 2006–2013

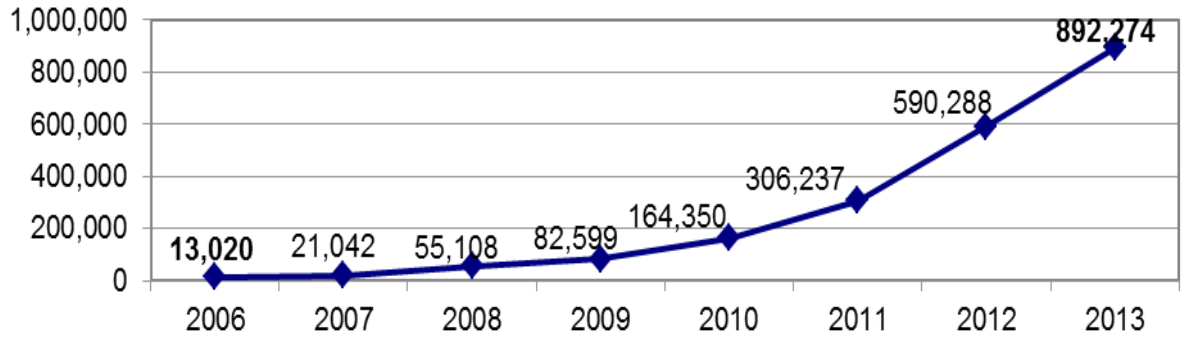

Figure 5.1: Health and Human Services Commission, 2014.

To educate clients about self-service options on YourTexasBenefits.com, HHSC placed computers in the lobbies of eligibility offices statewide and is working with community partners, as described below. As the number of clients using YourTexasBenefits.com increases, clients and applicants have greater flexibility while increasing the capacity of eligibility staff to focus on completion of timely and accurate eligibility decisions. As of August 2013, almost 50 percent of the applications processed by HHSC were submitted via YourTexasBenefits.com.

Planned Actions

HHSC will continue to enhance YourTexasBenefits.com during the strategic planning period of 2015–2019 as new technology becomes available, including the introduction of a mobile application to increase self-service options for clients. HHSC continues to pursue two key strategies to increase the number of client transactions conducted through online self-service.

Computers and Assistance in Local Office Lobbies

Over the last two years, HHSC has installed computers in the lobbies of eligibility offices with the goal of increasing client awareness of YourTexasBenefits.com features. Staff assists clients using the website and educates them about functionality of the system. Additional lobby computers continue to be added to offices as space allows.

Partnering with Community-Based Organizations

Many community-based organizations (CBOs) regularly provide information about HHSC programs and help clients apply for benefits as part of their mission. The

Community Partner Program (CPP) plays an important role in helping promote self-service options, especially YourTexasBenefits.com, to clients and applicants of HHSC programs.

House Bill 2610 (82-R) requires that community partner staff and volunteers be trained and certified as Your Texas Benefits Navigators. Since CPP began in January 2012, participation has steadily grown from 8 community organizations to more than 300 organizations by the end of fiscal year 2013.

Community Partners provide valuable feedback to HHSC on how to improve the eligibility process for clients.

HHSC supports the Community Partners by providing tools and support, including:

- Web-based training and instructor-led training, as needed;
- Updated communication and revised web-based training as HHSC introduces new website features;
- Technical assistance with using the website and understanding the application process;
- Community partner reports; and
- A web-based searchable database of available Community Partners (at texascommunitypartnerprogram.com).

Community Partners are an essential component of HHSC's overall strategy of leveraging technology to help meet the demand for eligibility services, in addition to being an important source of information about HHSC programs and services for Texans. HHSC will continue to nurture the CBO partnerships statewide during the next several years.

5.3.3 Strengthening Community Partnerships

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.
- Work closely with faith- and community-based organizations to assist people in applying for nutrition, medical, monetary, and other assistance.

Discussion

A significant number and variety of organizations across Texas are committed to working with people who receive and/or need HHSC program benefits or services. The challenge for HHSC is to provide those organizations with the information and tools they need to serve their clients effectively and to provide access to information about HHSC programs, services, and resources.

Recognizing the importance and potential of community partners, HHSC continues to seek new and innovative ways to support the efforts of these organizations to improve systems and better serve clients. HHSC has multiple mechanisms to promote effective coordination of communication with the organizations and to share resources in support of client needs.

Collaboration and coordination between HHSC and community partners occurs through the following established communication initiatives:

- HHSC Stakeholder Forum,
- Medicaid and Children's Health Insurance Program (CHIP) Regional Advisory Committees,
- Foster Care Coordinating Team,
- Outreach and Technical Assistance Workgroup,
- Texas Consortia of Refugee Providers, and
- Faith- and Community-Based Initiatives.

From these opportunities to share information and receive feedback, HHSC is able to make recommendations for program improvements.

HHSC maintains a variety of targeted client services contracts with diverse community partners across the state. Through these contracts, HHSC provides specialized services for critical needs populations:

- Refugees,
- Victims of domestic violence,
- Couples and individuals seeking educational opportunities to improve their relationships, and
- Expectant mothers.

Through the continuing administration of customer satisfaction and feedback surveys developed for this provider network, themes have emerged as priority areas for enhanced support of our community partners:

- Increased access to HHSC staff,
- Information regarding other HHSC programs, and
- Improvements in programmatic reporting tools.

Planned Actions

Community Partner Program

In addition to the ongoing coordination and collaboration, HHSC will continue to develop the Community Partner Program and recruit organizations that provide information about HHSC programs and help clients use YourTexasBenefits.com to apply for and manage their benefits. These partnerships provide clients with more options through which they can access services. HHSC will continue to incorporate feedback from partners to help strengthen training and support within the program.

Faith- and Community-Based Initiatives

To facilitate more effective partnerships with faith- and community-based organizations serving citizens in need, HHSC participates in the statewide Interagency Coordinating Group. Group members work to improve partnerships on several fronts:

- Improved contracting relationships,
- Enhanced training,
- Shared information and resources, and
- Development of cross-agency programs.

5.3.4 Maintaining Accountability and Integrity in a Changing Environment

Strategic Priority: Ensure the integrity of health and human service providers.

- Optimize the prevention, detection, and correction of fraud, waste, and abuse, focusing on high-risk areas.
- Continue to coordinate with managed care special investigative units to optimize the prevention, detection, and correction of fraud, waste, and abuse.

Adapting Functions to Managed Care

Discussion

The Office of Inspector General (OIG) has adapted its work and organizational structure to address the changes that have occurred in health law and policy in the last few years. With the expansion of Medicaid managed care and the passage of other health care legislation, the landscape of Texas Medicaid has undergone considerable change. OIG remains committed to fulfilling its critical role in the Health and Human Services (HHS) System by providing expertise, assistance, and

high-quality policy and process recommendations to HHS System program areas regarding program integrity, thus achieving OIG's central objective: to improve health and human services programs and operations by protecting them against fraud, waste, and abuse.

In the last two years, OIG has taken several steps to address the unique set of challenges presented by the large-scale expansion of managed care, including:

- Significantly increasing the size of its Medicaid Provider Integrity section to enhance its investigative efforts of managed care organizations (MCOs) and providers;
- Integrating its investigative and enforcement efforts with those of MCOs to provide efficient and rapid case investigations and recoveries; and
- Establishing a MCO Audit Unit that
  - Conducts comprehensive, risk-based audits of MCOs;
  - Detects fraud, waste, and abuse within these entities; and
  - Identifies issues of compliance with federal and state law and contractual requirements.

Planned Actions

- Continue efforts to integrate MCO encounter and claims data into new and existing detection tools to identify potential fraud, waste and abuse in the managed care setting.
- Continue to collaborate with HHSC's division for Medicaid and Children's Health Insurance Program (CHIP) to develop regular training for MCOs on the prevention and detection of fraud, waste and abuse.
- Continue to provide recommendations to HHSC's Medicaid/CHIP Division regarding revisions to the Uniform Managed Care Contract and Manual, as well as encounter and claims-related systems that may impact OIG's efforts to prevent, detect, and investigate potential fraud, waste, or abuse.
- Integrate OIG resources to ensure coverage of services delivered by MCOs under S.B. 7 (83-R), which were previously delivered by way of fee for service. These services include long-term care and inpatient hospital services.

Integration of Federal Medicaid Changes

Discussion

In March 2010, the Affordable Care Act was signed into law, requiring significant changes to public health insurance programs and provisions, some of which are listed here:

- New eligibility criteria;
- Enhanced program integrity provisions; and

- Comprehensive provider screening and enrollment requirements for all new and existing providers, including:
  - Disclosure of direct and indirect ownership or controlling interests,
  - Enhanced criminal history checks, and
  - Unscheduled on-site inspection visits.

These new federal requirements were incorporated into state law with the passage of Senate Bill (S.B.) 223 (82-R) and House Bill 1720 (82-R), with an effective date of March 23, 2012.

OIG has taken several steps in the last two years to implement these requirements, including:

- Participating on several HHS System workgroups related to implementation of the new federal law,
- Publishing new rules that incorporate the new provider screening and enrollment requirements,
- Working with HHSC's Medicaid/CHIP Division to develop new provider disclosure forms and to identify system changes needed for capturing the new disclosure requirements,
- Conducting unscheduled on-site inspection visits for medium- and high-risk providers as part of the enrollment process, and
- Suspending payments to providers upon verification of a credible allegation of fraud.

Planned Actions

- Continue working with HHSC's Medicaid/CHIP Division to enroll and re-enroll all providers in accordance with the new screening requirements.
- Continue efforts to provide training to providers on a variety of topics, including procedures for credible allegations of fraud and other types of payment holds, as well as procedures for overpayments.

Expanded Scope of Authority in State Psychiatric Hospitals

Discussion

As a result of the passage of S.B. 152 (83-R), criminal allegations of abuse, neglect, and exploitation in state psychiatric hospitals will continue to be referred to OIG Internal Affairs for investigation. OIG has engaged additional peace officers dedicated to implementing S.B. 152 (83-R) and has established a separate investigative unit that is specifically tasked with investigating criminal allegations at all state psychiatric hospitals.

Planned Actions

- Continue to collaborate with the Department of Family and Protective Services (DFPS) and the Department of State Health Services to follow established protocols for referring all criminal allegations of abuse, neglect, and exploitation for investigation within state psychiatric hospitals for investigation.
- Continue to collaborate with DFPS and the Department of Aging and Disability Services to follow protocols for referring all criminal allegations of abuse, neglect, and exploitation within the State Supported Living Centers to OIG for investigation.
- Continue to provide training for state hospital employees and managers on investigations and their responsibilities.
- Continue meeting with District Attorney's offices in counties where state psychiatric hospitals are located to educate on the types of investigations and referrals to be expected.

5.4 Internal Challenges and Opportunities

Internal matters also affect HHSC's success. To ensure good outcomes in all programs, the agency reviews and evaluates its own performance, then uses the analysis to address the issues that are most significant.

5.4.1 Continuous Improvement of Business Processes

The Health and Human Services (HHS) System agencies are committed to improving business processes both within each agency and across the HHS System. HHSC has several areas currently under review.

Workload Management in Eligibility Determination

Discussion

In recent years, HHSC has experienced dramatic growth in the number of program recipients, up nearly 46 percent between 2007 and 2012, without a proportionate increase in eligibility determination staff. Various initiatives and greater utilization of YourTexasBenefits.com has helped eligibility staff maintain high performance levels during this time. With caseloads expected to continue to increase, HHSC must look beyond technology to identify opportunities for efficiency.

Planned Actions

With this goal in mind, HHSC is examining the business processes that support eligibility determinations to identify opportunities to remove unnecessary or duplicative tasks performed by staff. Recommended refinements are being developed by frontline eligibility staff and are expected to enable the agency to manage current and future workloads more effectively.

Medicaid Information Technology Architecture

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

Streamlining Contract Management

Discussion

Each agency works with HHSC's Procurement and Contracting Services (PCS) to improve contract management across the HHS System, streamlining and standardizing where appropriate.

A workgroup of representatives from the agencies in the HHS System was formed to develop comprehensive contract management instructions in the HHS Contract Manual guide. This manual documents standard policies and practices necessary to manage all HHS System contracts effectively. To ensure its uniform application, the manual's use is mandated throughout the HHS System.

In conjunction with the development of the HHS Contract Manual, PCS is developing a training program for contract managers, in coordination with the Texas Comptroller of Public Accounts. S.B. 1681 (83-R) requires that all state agency contract managers be certified by September 1, 2015.

Planned Actions

PCS is researching technology to develop and maintain a comprehensive HHS System database for monitoring and reporting of contracting activities.

5.4.2 Maintaining and Developing the Workforce

HHS Executive Leadership Academy

Discussion

To promote the development of staff, Health and Human Services (HHS) System agencies must make a commitment to grow the skills and talents of managers as part of a plan for succession. The HHS System has demonstrated this belief by establishing an Executive Leadership Academy (ELA), a succession planning and mentoring program that will enhance needed employee skills. The ELA provides development and mentoring opportunities to enhance the growth of high-potential participants as they take on greater responsibility in positions of leadership. The primary goals of the ELA are to:

- Prepare participants to take on increased and broader roles and responsibilities,
- Provide opportunities to better understand critical management issues,
- Provide opportunities to participate and contribute while learning, and
- Create a culture of collaborative leaders across the HHS System.

Through this planned development of leadership and management skills and the careful selection of qualified staff, the HHS System will continue to meet the challenges posed by increased retirements.

Planned Actions

The ELA will continue to develop and offer leadership development courses and programs that help HHS System agencies meet their needs as the workforce changes.

5.4.3 Addressing Infrastructure Needs

Physical Security of State Offices

Discussion

The safety and security of health and human services staff and customers are always a priority. HHSC's Business and Regional Services (BRS) will continue to conduct vulnerability assessments of Health and Human Services (HHS) System facilities and local practices and recommend mitigations of issues. With guidance from BRS, HHS System offices will be required to develop office emergency action plans to pre-identify risks and roles and responsibilities in the event of an incident.

Planned Actions

BRS will continue to provide incident command and response leadership when incidents occur and will maintain ongoing security awareness through facilitation of the Emergency Management Council, Regional Administrative Councils, provision of incident management training and development of desktop references and tools.

Office Space Reductions

Discussion

Evolving technology, service delivery practices, and staffing models provide an opportunity to decrease the brick and mortar footprint of HHS System offices across the state. As leases approach their end dates, BRS assesses the possibility of providing services from alternate existing or virtual locations and de-leasing all or portions of the space as it comes due for renewal. As opportunities arise to vacate mid-lease properties, BRS provides executive leadership with options to consolidate or co-locate offices, to increase efficiency and decrease lease costs over time.

Planned Actions

BRS will continue to address space needs across the HHS System and, wherever possible, work to eliminate or reduce some leases throughout the state.

Information Technology

Discussion

Through the use of technology and information systems, HHSC Information Technology (IT) improves the agency's service delivery to its customers in the most efficient and secure way possible. Providing additional functionality and access mechanisms while ensuring security, performance, and legal compliance requires complex coordination and analysis across a broad variety of stakeholders. HHSC IT strives to meet both these objectives as it implements improvements in business processes and service delivery.

As the state of technology matures, along with the ability to secure data in transit and stored on various environments, it is becoming increasingly possible to provide remote and mobile functionality to a variety of workers, and also to meet the agency's and customers' needs by providing additional ways for clients to access services and information. Clients and employees expect the HHS System to enhance communications channels, and HHSC IT continues to evaluate innovations in the industry. Using new technologies such as cloud services, where HHSC would procure a service and the vendor would handle the technical infrastructure required to provide the service, could decrease HHSC's need to build and maintain its own infrastructure, and possibly allow easier access to new technologies with enhanced

features. While these innovations may reduce space and maintenance requirements, expanded technology capacity and security enhancements will be needed to support remote access to the agency's systems and data.

Planned Actions

HHSC has several modernization efforts underway to ensure that the agency's software systems and data are secure, comply with federal and state rules and regulations, and offer optimal performance and value. These efforts include:

- Updating eligibility and Medicaid systems and processes,
- Making systems more modular and interoperable with other systems, and
- Implementing data warehouse functionality for improved reporting and decision-making.

5.4.4 Improving Data Quality and Use

Obtaining Managed Care Data to Ensure Quality

Discussion

Obtaining reliable data on managed care providers and services is an area that has been targeted for improvement. Some success has been achieved, but challenges still remain. Provider information is not always current in the Medicaid claims administrator system, and client information is also difficult to keep current, due to the mobility of clients in the population.

Planned Actions

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 future modifications to address certain errors in categorization for primary care providers;
- Identifying and correcting inaccurate client 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

Discussion

The goal of health information technology (HIT) is to allow comprehensive management of medical information and its secure exchange among health care consumers, providers, and payers to improve the quality of care, prevent medical errors, reduce health care costs, and increase administrative efficiencies. To achieve this goal, numerous state and federal HIT initiatives must be effectively coordinated.

Planned Actions

HIT includes the following areas and initiatives.

Health Information Exchange

The federal American Recovery and Reinvestment Act of 2009 provides funding to states to plan for and implement statewide health information exchange (HIE) systems. To ensure the coordination of statewide HIT activities, in October 2009, HHSC received a $28.8 million federal grant to plan and implement a statewide HIE. With assistance from a contractor, HHSC developed an HIE grant program through which local initiatives are being funded to develop HIE networks. HHSC also contracted for the following services:

- Coordination of state-level HIE governance and policy development,
- Development of state-level HIE technical shared services, and
- Administration of a market for health information service providers to offer connectivity for health care providers in areas of the state without a local HIE initiative.

HHSC is exploring establishing connectivity to the state-level HIEs in order to obtain clinical data on Medicaid clients.

Medicaid Electronic Health Record Incentive Program

The American Recovery and Reinvestment Act of 2009 also created the Medicaid Electronic Health Record (EHR) Incentive Program to encourage eligible Medicaid providers to adopt, implement, or upgrade to certified electronic health record technology and to use this technology in a meaningful way, known in this policy area as “meaningful use.” HHSC launched the Medicaid EHR Incentive Program in March 2011 and began disbursing incentive payments to eligible professionals and hospitals in May 2011. HHSC continues to encourage Medicaid providers to participate in the program and to achieve meaningful use.

HHSC is conducting studies to assess barriers that constrain Medicaid providers from obtaining EHR systems. Additionally, HHSC is developing a base to conduct analytics using data from the EHR incentive program.

e-Prescribing

To reduce adverse drug events and Medicaid costs incurred in providing prescription drug benefits, HHSC upgraded its pharmacy benefits system to provide e-prescribing functionality. The project was implemented December 2012 making the following functions available to fee-for-service providers and pharmacies.

- The drug formulary for Medicaid and the Children's Health Insurance Program (CHIP) is now available to prescribers electronically. Prescribers' EHR systems can download regularly updated formulary information that is seamlessly integrated into their prescribing interface.
- Client prescription benefit eligibility is integrated into prescribers' EHR systems as well as pharmacies' management software. Medicaid/CHIP client eligibility will be verified in a timely manner by providers and pharmacies, ensuring clients receive the full benefit of their enrollment and improving access to prescription drugs.
- Medication histories of Medicaid/CHIP clients are available for providers and pharmacies, integrated alongside formulary and benefit eligibility information.

Electronic Health Histories for Medicaid Clients

The 81st Legislature directed HHSC to develop a Medicaid-based electronic health record system to support improved quality of care by giving providers more and better information about their patients. In 2013, HHSC developed the capability to display electronic health histories for Medicaid clients to Medicaid providers. The electronic health histories were implemented in a way that gives clients control of the sharing of their health information and ensures the privacy of the client and the confidentiality of the health information displayed. The electronic health histories contain immunization history from the state's immunization registry, last date of medical and dental check-ups, and reminders for providers when a medical or dental check-up is due. Subsequent releases are planned for 2014 that will add diagnoses, procedures, prescription history, and lab results to the electronic health histories. HHSC also plans to include on-line explanation of benefits verification and to make the system available via mobile technology.

Enterprise Data Governance

Discussion

The Enterprise Data Governance (EDG) initiative will address the Health and Human Services (HHS) System's challenges of managing data assets across a complex

collection of systems, architectures, and data stores to help empower the System agencies. The EDG will establish the policy and process framework to:

- Drive data standardization,
- Enable improved data quality,
- Reduce data redundancy,
- Improve data-sharing, and
- Facilitate advanced reporting capabilities across the HHS System.

EDG activities to date include:

- Developing a strategic roadmap for EDG program implementation;
- Establishing a cross-agency Enterprise Data Governance Council and Steering Committee to oversee EDG program implementation;
- Establishing the Chief Data Officer role to provide System-level vision, oversight, and expertise in the area of data governance; and
- Operationalizing the following foundational EDG elements:
  - Identifying Medicaid member and provider attributes that are stored across the enterprise;
  - Collecting information about that data (metadata) and the implementation of a System-wide metadata repository;
  - Facilitating the creation of a single, well defined master version of all the data entities, or “golden record,” for Medicaid members and providers; and
  - Developing key EDG operational components including policies, processes, metrics, and communication/training plans.

Planned Actions

For the 2014–2015 biennium, EDG will also focus on supporting these key strategic Medicaid program initiatives:

- HHS Enterprise Data Warehouse (EDW), described below; and
- Medicaid Management Information System (MMIS) re-procurement.

The EDG organization will support many other Medicaid and non-Medicaid HHS System initiatives. Medicaid initiatives will include:

- Conversion to ICD-10, the new classification list for medical diagnoses that the Centers for Medicare and Medicaid Services is scheduled to begin using in late 2015,
- HIEs, and
- Supporting the Medicaid Information Technology Architecture (MITA) initiative for applicable MMIS projects.

Enterprise Data Warehouse

Discussion

In accordance with legislative direction, HHSC is developing an Enterprise Data Warehouse and Business Intelligence (EDW/BI) solution for strategic decision-making and operational improvements to Medicaid and other programs in the HHS System. The cross-agency integration of data will help:

- Determine how health care services can be improved,
- Evaluate program effectiveness,
- Determine more cost-effective means of delivering services,
- Assist with the detection of fraud and abuse, and
- Aid in the forecasting of future human services needs and priorities.

The EDW/BI will align and complement the goals and objectives of other HHS initiatives, including enterprise data governance, MMIS projects, HIEs, and MITA. The EDW will establish a unified and contextually accurate view of clients and providers, and it will incorporate data governance to ensure the information is reliable and secure. The EDW/BI will enhance access to usable, consistent information to solve problems and to reveal trends. HHSC's vision for an EDW/BI solution includes:

- Minimizing the labor intensity currently required for queries and reporting;
- Improving health quality outcomes through 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.

In its planning phase, EDW/BI completed:

- A business needs assessment;
- A solution alternatives analysis;
- A cost-benefit analysis; and
- Release of a draft request for proposal for design, development, and implementation (DD&I) services.

Planned Actions

The DD&I services vendor is to be selected in 2014.

The first three releases of the EDW will establish its core functionality for:

- Strong data management for Medicaid;

- A single, accurate, and authoritative view of the data; and
- Improved reporting, analysis, and advanced analytics.

Future releases will incorporate external data sources and expand analysis of strategic health care initiatives. The EDW will allow further consolidation of enterprise data sources through the migration of existing business intelligence and data mart environments.

5.5 Agency Goals: Target Populations and Services Descriptions

HHSC has three very different kinds of responsibilities.

- Goal 1 of the appropriations bill directs HHSC to take responsibility for oversight of the HHS System.
- Goals 2 through 4 direct HHSC to administer Medicaid and other programs to clients.
- Goal 7 directs HHSC's Office of Inspector General to combat waste, abuse, and fraud in HHS programs.

These responsibilities are described below.

5.5.1 HHSC Goal 1: HHS Enterprise Oversight and Policy

HHSC is accountable to Texans for ensuring that the consolidated Health and Human Services (HHS) System agencies provide high-quality services as efficiently and effectively as possible. Specifically, HHSC:

- Coordinates and monitors the use of state and federal money received by HHS System agencies;
- Reviews state plans submitted to the federal government;
- Monitors state health and human services agency budgets and programs, making recommendations for budget transfers;
- Conducts:
  - Demographic research and analyses,
  - Provider rate analysis and actuarial analysis, and
  - Projections of caseloads and costs;

- Directs an integrated planning and budgeting process across the five HHS System agencies; and
- Develops and implements initiatives that are relevant, timely, and cost-effective.

The rest of this section 5.5.1 describes several initiatives HHSC is leading.

Mental Health Coordination

Discussion

The challenges associated with mental health conditions are tremendous. In addition to the individual personal suffering, mental illness touches every aspect of society. While in recent years Texas has made strides toward enhanced mental health services, education, and supports, Texans with mental health conditions continue to be faced with significant hurdles. The mental health of Texans has a direct impact on nearly every aspect of life, including economic productivity, student success, criminal justice, and public health and safety.[1]

Treating mental health conditions has a major cost impact/burden on the individual, the family, health care insurers, and providers. An estimated $77.6 billion was spent nationally on medical treatment of mental disorders in 2011; however, the total economic burden from mental disorders is much larger.[2]

Not treating mental health conditions when they occur also has a fiscal impact, whether through lost opportunity or funds expended. When people are too ill to work, they may lose wages or lose employment entirely. The annual loss of earnings alone was estimated to be at least $192 billion.[3] When employees are ill, employers may lose productivity. This loss of worker productivity has been estimated to be more than $171 billion per year nationally, and more than $10 billion per year in Texas.[4] Mental health conditions are also associated with chronic medical diseases such as cardiovascular disease, diabetes, and obesity, causing increased use of emergency room and hospital services due to these and other co-morbid conditions, adding an even greater economic burden. The cost of serious mental illness, including the cost of treatment, lost earnings due to mental illness, and the cost of disability benefits, has been estimated at $317 billion per year.[5]

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[1] Hogg Foundation for Mental Health (November, 2012). A guide to understanding mental health systems and services in Texas. Retrieved from www.hogg.utexas.edu.
[2] Agency for Healthcare Research and Quality (2011). Medical Expenditure Panel findings. See: http://meps.ahrq.gov/mepsweb/
[3] Kessler, R.C., Heeringa, S., Lakoma, M.D. et al. (2008). Individual and societal effects of mental disorders on earnings in the United States: Results from the National Comorbidity Survey Replication, American Journal of Psychiatry, 165: 703-711. The study does not include people with schizophrenia, who have a very high unemployment rate and would add to the estimate.
[4] The Milken Institute (2007). http://www.chronicdiseaseimpact.com/ebcd.taf?cat=disease&type=emotional
[5] Insel, T.R. (2008). Assessing the economic costs of serious mental illness. American Journal of Psychiatry, 165: 663-665.

Much of the cost associated with mental illnesses cannot be fully captured in dollars and must be estimated in terms of life quality. The disability-adjusted life year is a common measure used to assess the impact of adverse events on a person. Using this metric, mental illnesses are the most disabling health conditions, accounting for 37 percent of all healthy life years lost across all non-communicable disease conditions.[6]

A number of mental health trends exist in Texas, including the following areas.

- **Deficiencies in Coordination and Collaboration—**Twenty to seventy percent of the populations served by state funded agencies have mental health conditions, yet Texas lacks consistent, formalized, cross-agency approaches and processes regarding services, program coordination, training, supports, and funding to address the mental health needs of Texans. People with unmet mental health needs frequently are seen throughout multiple Texas systems, often on an as-needed basis, rather than through a consistent and planned approach. This patchwork system of services includes the adult and juvenile criminal justice systems, hospital emergency rooms, schools, child protective services, and other social service settings where services may be provided on a fragmented basis and, as a result, are less effective.
- **Prevention and Early Intervention Services—**Studies indicate that better outcomes are achieved through prevention and early intervention services than through more restrictive and costly alternatives, such as jails, prisons, and hospitals. While in recent years Texas has invested significant funding in crisis and mental health first aid training, the majority of state mental health funding is focused primarily on treatment as opposed to prevention and early intervention services and supports.
- **Innovation in Funding and Service Delivery Programs—**Current traditional public mental health funding in Texas is channeled through nearly a dozen state agencies, contributing to a fragmented and poorly integrated system. Waiver projects, such as the Medicaid 1115 Transformation Waiver demonstration project begun in Texas in 2012, show promise, with innovative, locally-driven projects that allow for flexibility in funding to address unique local needs and produce more favorable outcomes.
- **Veteran and Active Service Members Supports—**Nearly 1.6 million veterans reside in Texas. A number of veterans experience mental health challenges resulting from their military service, but they may feel a general reluctance to engage in mental health treatment. The effects of war also can extend beyond the deployed service member; children and families can struggle with changes resulting from absent and returning parents.
- **Peer Services—**Recovery is a core value of the Texas system, and Texas leads in many areas, promoting self-directed care for people with mental illness through peer-delivered services. Peer support research has reported increased

[6] World Health Organization. (2011). Global status report on non-communicable diseases 2010. Geneva: WHO. See discussion at: http://www.nimh.nih.gov/about/director/2011/the-global-cost-of-mental-illness.shtml

consumer engagement of care services, reduced inpatient and emergency room care, and reduced substance use among people with co-occurring disorders.

Planned Actions

The 83rd Legislature invested an additional $300 million in the state's behavioral health care system for the 2014–2015 biennium. The funding is critical to communities across the state. To ensure a strategic statewide approach, the Legislature also directed HHSC to designate an executive-level staff person to lead a statewide mental health coordination initiative, working in conjunction with the Department of State Health Services (DSHS), local governments, non-profit mental health organizations that are publicly-funded, and other relevant state agencies.

Mental Health Coordination will serve as a catalyst to develop an accountable system of mental health care that directs performance to achieve meaningful clinical and cost-effective outcomes that improve service access, coordination, collaboration, barrier elimination, and innovation among statewide systems of care. These efforts will provide overall vision and leadership for mental health services in Texas, consulting and coordinating with state-funded agencies and stakeholders to develop a statewide plan for a transformed mental health system.

In this planning period, the following activities will help fulfill the legislative direction.

- Develop a statewide strategic mental health plan that directs the vision and guiding principles to be adopted across state agencies.
- Evaluate and address network adequacy, funding methodology, system oversight, and service sustainability.
- Enhance mental health services and supports to Texas military service members and veterans.
- Provide statewide mental health oversight, planning, coordination, and direction across all state funded agencies.
- Review and recommend improvements regarding mental health policies, practices, and programs to promote effective program administration and service delivery focused on achieving statewide mental health objectives.
- Provide information and counsel to HHS System management on mental health trends and their impact.
- Identify and reduce overlap and duplication of effort in the provision of services and funding streams.
- Seek innovative alternative approaches to address current gaps in care.

HHSC Veterans' Initiative

Discussion

As of September 2013, Texas is home to nearly 1.7 million veterans, ranking second to California, which has approximately 1.8 million veterans.[7] These Texas veterans include approximately 1.3 million wartime veterans. There are approximately 1.5 million men and approximately 200,000 women veterans. Many veterans either entered service in Texas or were stationed at one of the military bases located across the state and remained in the state after discharge.

These veterans and their families frequently need a variety of services and supports, including physical and behavioral health care services, employment opportunities, housing, education, and financial assistance. Moreover, veterans today often have needs that did not exist for their predecessors. Additionally, in some cases services are currently available to meet these needs, but how to identify those services and how to access them is not well known.

To help bridge this gap, HHSC created the Veterans' Initiative to lead a multi-agency effort to strengthen services for veterans. This initiative focuses on opportunities and policy changes to assist veterans in navigating the myriad of services, including the following activities.

Current Activities

Statewide Deployment of the Texas Veterans Portal

The Texas Veterans Commission manages this website as a resource for veterans, their families, and their survivors. It includes helpful information from many government agencies regarding assistance, services, and benefits. The HHSC Veterans' Initiative is spearheading and coordinating efforts to ensure that all Texas agency websites include this portal. The Veterans' Initiative is working with county governments to include this portal in county government websites, and thereafter will work at the local level to extend the portal to city government and to private industry.

HHS System Advocate for Veterans

The Executive Commissioner for HHSC charged the HHS System Commissioners and the HHSC executive team to develop strategies and/or activities to assist, serve, and facilitate veterans in the HHS workforce more effectively. In December 2013, the human resources unit established a Veterans' Advocate position to provide veterans a single point of contact for any unique work related issues, concerns, or assistance that may be directly or indirectly associated with or related to being a veteran. In January 2014, a full-time Veterans' Advocate was hired with the primary objective of assisting HHS agencies in recruiting and retaining qualified veterans.

[7] United States Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, 2014.

The Veterans' Advocate works with program representatives to develop and strengthen a military-friendly culture for veteran employees. The Veterans' Advocate regularly meets with hiring managers to promote veteran employment, builds applicant resources to create qualified pools, and contacts community services and resources to promote veteran employment.

Employed Veteran Email System

This email system was created to enable employed veterans to communicate regarding any issue that affects them as veterans and their family members. As part of this email system project, the Veterans' Initiative helped to establish a section in the HHSC employee newsletter, *The Connection*, called the Veterans Outpost. This section is devoted to the interest and enlightenment of employed veterans and veteran family members. Future plans include extending this model to other state agencies.

The Texas Veterans App

This free smartphone application was recently made available to veterans, veterans' family members, friends, employers, health professionals, volunteers, and anyone who desires to help make access to veterans' services and supports much easier and quicker. Plans for marketing this mobile phone application are being developed.

Faith-Based Initiatives

The HHSC Veterans' Initiative is partnering with the Texas Armed Forces State Chaplain and others to coordinate an outreach program to faith-based community leaders, including clergy, who currently interact with the military. Many faith-based community leaders have expressed an interest in reaching out to those who have served in the military, but these leaders are unaware how to proceed. Plans are being developed to provide a template for those leaders to market a Ministering to the Military event during Veterans' Day weekend 2014, with the intent to make it an annual event. The program will be designed to assist faith communities in encouraging local veterans and active duty personnel and their families to attend, as well as provide cultural awareness for those non-military leaders. The template will be created and the event held with an expectation of creating a support network for those in attendance.

Ongoing Pilot Therapies

Research is in progress at Carrick Brain Centers & the Center for Brain Health, The University of Texas at Dallas, to develop innovative ways to treat post-traumatic stress disorder.

Planned Actions

The Veterans' Initiative has outlined a multifaceted approach to better assist veterans. Some of the planned activities include the following.

- **Web-Based Training Programs—**Developing and providing Web-based training programs to teach military cultural competency to the public.
- **Veterans' Services and Supports—**Increasing knowledge and provision of improved coordination of these services and supports to veterans and their families.
- **"Strike Force" for Military and Veteran Families Undergoing Investigations by Child Protective Services (CPS) or Adult Protective Services (APS)—** Developing, implementing, and enhancing a "Strike Force" for military or veteran families undergoing CPS or APS investigations, to address the high rate of investigations in families of veterans and active duty personnel. This high rate could be partially as a result of repeated deployments and the stress that can occur in the home. A rise in diagnoses of post-traumatic stress disorder and traumatic brain injuries may also play a role in the discourse. It has been reported that having someone who is culturally competent, especially one who is a veteran, present during investigations may lead to more beneficial outcomes. This Strike Force could also have a secondary positive benefit of increasing employment of veterans in meaningful ways.

Women's Health Coordination Initiative

Discussion

As noted in other parts of this Strategic Plan, the health care needs of women in Texas are varied, and services for women's health are provided through a variety of programs and funding sources. Some of the data reflecting these needs includes the following.

- Approximately 3.3 million women in Texas are at or below 200 percent of the federal poverty level.[8] Of these low-income women, 20 percent are estimated to be enrolled in Medicaid and are eligible for full medical benefits,[9] with the remainder most likely in need of health care.

[8] This estimate is persons of all ages at or below 200 percent of the federal povery level (FPL) multiplied by the percent of all persons at or below 100 percent of FPL who are women over 18. 2007-2011 American Community Survey 5-Year Estimates, United States Census Bureau. (Dec. 2012). Available from DataFerrett Tables S1701 and B17001 http://dataferrett.census.gov/

[9] Women Medicaid Enrollees are females ages 18 and older who are enrolled in Medicaid and eligible for full medical benefits (654,106), and this figure does not include women in the Texas Women's Health Program (TWHP), who have access to a more limited set of benefits. Under the TWHP, there was separate group of 105,464 women ages 18 and older enrolled in the same month. Also, approximately 5 percent or less of all women in the Medicaid program come from a gross income background higher than 200 percent of FPL. Texas Medicaid Enrollees Eligible for Full Medicaid Medical Benefits By County (September 2013). Source: Texas Medicaid Program. Data Compiled by: Demography/GIS Team, Strategic Decision Support, HHSC, 04/25/2014.

- Rates for teen pregnancy (ages 13 through 17), while steadily decreasing from 21.4 per thousand female teens in 2010 to 16.4 in 2012, are still a concern.
- Approximately 54 percent (204,000) of all Texas births are paid by Medicaid.
- More than 67 percent of Medicaid costs for hospitalized newborns are directly related to costs related to prematurity.
- Although multiple state programs serve women's preventive care, primary care, and family planning needs, HHSC continues to examine ways to increase access to care and coordination among programs.

To enhance statewide coordination of the various women's health programs in Texas, HHSC created the Women's Health Coordination Initiative in 2013. This initiative works across agency lines to improve the way health care services are delivered to low income women in Texas—including preventive health care screenings and treatment, contraceptives, treatment for certain sexually transmitted infections, breast and cervical cancer treatment, and prenatal services. In particular, it seeks to improve coordination of processes and policies within and across agencies to help women's health programs offer better continuity of care, particularly for women transitioning between programs, and promote best clinical practices to improve overall health and birth outcomes.

In 2013 the Texas Legislature added $100 million over the next two fiscal years for a new program called Expanded Primary Health Care (EPHC), administered by DSHS. This program will provide:

- Primary, preventive, and screening services to eligible women;
- Outreach and direct services through community-based clinics under contract with DSHS; and
- Community health workers to ensure women have access to appropriate preventive and screening services.

The Women's Health Coordination Initiative will seek input from stakeholders and help to ensure that they understand the new program and to ensure the new initiative complements other state women's health programs, primarily the Texas Women's Health Program (TWHP) administered by HHSC and the Family Planning (FP) Program administered by DSHS.

Planned Actions

This initiative will develop a comprehensive website that will help women navigate the state's programs and services. This website will include information on a variety of services, including family planning programs at HHSC and DSHS, breast and cervical cancer screening and treatment, new expanded primary care services, and services for pregnant women and mothers.

The initiative will develop the primary goals and objectives to improve women's overall reproductive health and birth outcomes and implement policies that reinforce these goals across the enterprise. Some specific objectives include the following.

- Continue to educate women and providers about the array of family planning and primary care services available and how to navigate among these programs through development of a comprehensive women's health program website, initially focusing on TWHP, FP, and EPHC.
- Provide increased continuity of care for women transitioning between health care programs.
- Increase utilization of effective forms of long-active reversible contraception.
- Increase spacing between pregnancies.
- Reduce preterm birth rates and elective delivery rates prior to 39 weeks of gestation.
- Increase access to prenatal care, to improve the overall health of women and improve birth outcomes.
- Provide health plans access to birth record and historical claims data for all women entering the Pregnant Women's Medicaid Program to provide timely, targeted care to mothers at risk for repeat pre-term birth.

Elimination of Disproportionality and Disparities

Discussion

Center for Elimination of Disproportionality and Disparities

Pursuant to S.B. 501 (82-R), the Center for Elimination of Disproportionality and Disparities assists HHS System agencies and other entities serving vulnerable populations in eliminating disproportionality and disparities, including health disparities, allowing for the improved health and well-being of Texans.

The center includes the following areas: the Office of Minority Health and Health Equity, the Office of Border Affairs, and regional Equity Specialists located throughout Texas. The center grounds its work, at both the state and regional levels, in the Texas Model: A Framework for Equity. The Texas Model guides state planning, operations, and the development of effective collaborations across systems and meaningful community partnerships. It has five components, as depicted in Figure 5.2 below.

Figure 5.2

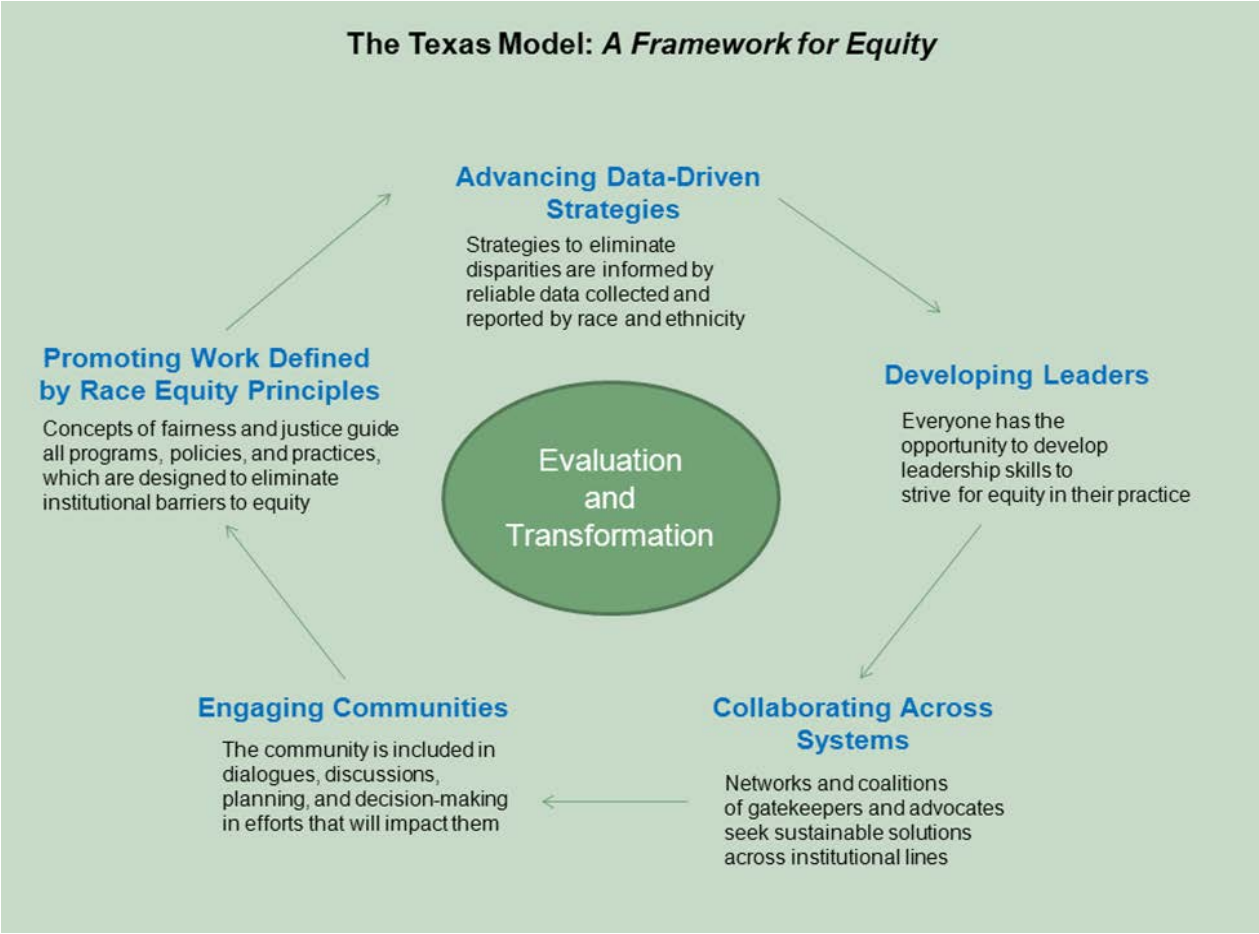

Figure 5.2: Health and Human Services Commission—Center for Elimination of Disproportionality and Disparities

The Texas Model is not a linear, step-by-step process; rather, each component works in support of the others.

The center's state office leads work to eliminate disproportionality and disparities within Texas health and human services agencies. The center supports reform efforts at each of the HHS System agencies: HHSC, the Department of Family and Protective Services, DSHS, the Department of Aging and Disability Services, and the Department of Assistive and Rehabilitative Services. The center is also responsible for establishing effective executive level partnerships with the HHS System agencies as well as other organizations, such as the Texas Education Agency, the Office of the Attorney General, the Texas Juvenile Justice Department, public schools, universities, and many others. The center supports the HHS System

agencies, other systems that serve individuals, communities, and partners with data analysis and collection by race and ethnicity.

Equity and Inclusion

The center does not have regulatory oversight over HHS System agencies; rather, the center's role is to provide expertise in community engagement, the Texas Model, and reform efforts aimed at reducing and eliminating racial disproportionality and disparities. This is accomplished through the regional equity specialists working in communities across Texas in partnership with:

- Other HHS System agencies;
- Nonprofit organizations, including faith-based organizations;
- Government entities at the local, county, and state levels; and
- Community stakeholders.

The specialists provide technical assistance, training, and consultation to support the development of collaborations across systems and strategies to reduce and ultimately eliminate disproportionality and disparities within health and human services, education, juvenile justice, health, mental health, and other systems. The specialists:

- Identify, analyze, and disseminate outcome data across multiple systems;
- Identify where disproportionality and disparities exist;
- Explore the underlying causes; and
- Help develop best practices with collaborative partners.

Advisory Committees

The specialists engage communities to establish regional advisory committees by developing partnerships with individuals, families, stakeholders, faith- and community-based organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.

Office of Minority Health and Health Equity

The Texas Office of Minority Health and Health Equity (TOMH/HE) is a central repository for minority health resources to meet the needs and to increase the ability of health service departments and programs, universities, and community-based organizations to address health disparities in an efficient, transparent, and accountable manner. TOMH/HE provides support and guidance to these entities to advance health equity and to enhance their capability to provide equitable, respectful, high-quality services to culturally diverse communities. The TOMH/HE works or contracts with state and federal agencies, universities, private interest groups, communities, foundations, and offices of minority health to develop health initiatives to reduce or eliminate disparities in health and health care access among

racial, ethnic, multicultural, disadvantaged, and other disparate populations and to promote the adoption of culturally and linguistically appropriate health-related services. The TOMH/HE works in partnership with communities and organizations in the public and private sectors to support a systems approach for eliminating health disparities.

In addition, the TOMH/HE will support national, state, and regional health-related priorities and coordinated responses through focused evidence- or practice-based initiatives. The TOMH/HE will serve in these capacities through five areas of concentration while addressing components of the Texas Model: knowledge and skills enhancement; health information, data, and research; programmatic guidance, implementation, and evaluation; transformational collaboration and networking; and workshop facilitation and training.

Office of Border Affairs

The Office of Border Affairs was established to improve the quality of health and human services in communities and colonias along the Texas-Mexico border. The office is comprised of staff located in the border regions and in Austin. The office coordinates information and resources, and it works with stakeholders to increase knowledge of and access to services. Activities include:

- Coordinating service-delivery with community-based organizations and state, federal, and Mexican agencies;
- Coordinating training for state agency staff to increase cultural responsiveness and good customer service;
- Developing new methods to improve outreach to residents of colonias;
- Leading the development of a consolidated appropriations request for colonias; and
- Implementing ways to stabilize the Promotora workforce.

More information about border regions initiatives may be found in Chapter 4, Section 4.1.5.

Planned Actions

The center will expand efforts to identify and eliminate disproportionality and disparities across systems during 2015–2019 by:

- Expanding engagement of communities by establishing regional advisory committees in border and rural areas;
- Including the Texas-Louisiana Region in efforts to improve the quality of health and human services in rural, isolated, unincorporated communities lacking basic or sufficient infrastructure;

- Creating tools and models that can be used to achieve equity where racial disparities exist; and
- Collaborating with federal and state partners and communities in culturally appropriate initiatives that include training for Culturally and Linguistically Appropriate Services adoption and certification of managed care organizations and providers.

Coordinated Strategy for Early Childhood Services

The Office of Early Childhood Coordination was established to promote community support for parents of young children and to provide for the seamless delivery of services to ensure that children are prepared to succeed in school and in life. This office evolved into the Office of Health Coordination and Consumer Services (HCCS) as part of a broader effort to coordinate specific services for vulnerable populations across HHS agencies, to improve health, education, financial stability, and child safety and well-being outcomes for young children and their families.

Several projects are in place within HCCS, including the Healthy Child Care Texas program, which trains and certifies child care health consultants to improve health and safety in child care settings. The Texas Home Visiting program and the Texas Nurse-Family Partnership program, described below, support pregnant women and their families in circumstances that are associated with risks to maternal and child well-being.

Texas Home Visiting

The Texas Home Visiting (THV) program was established in 2011 by a federal Maternal Infant Early Childhood Home Visiting (MIECHV) grant. Funding currently extends through September 2016. The grant supports the development and implementation of home visiting programs and contributes to the development of a comprehensive early childhood system that promotes maternal health, infant and early childhood health and development, safety, and strong parent-child relationships in Texas communities.

Target Population

The THV program serves pregnant women, children from birth to age five, and their families in at-risk communities. The communities were selected based on needs assessments for each county across the state, measuring prevalence of the following: poverty, preterm birth, juvenile crime, family violence, longitudinal school drop-out, unemployment, child maltreatment, and combined substance abuse. Due to the high correlation between premature births and low-birth weight and infant mortality, preterm birth rate was used as the only birth outcome.

As of February 2012, the following nine areas were selected to receive funding to develop early childhood community systems and develop or expand 28 evidence-based home visiting program sites:

- Cherokee and Anderson Counties;
- Dallas County;
- Ector and Midland Counties;
- Gregg County;
- Hidalgo, Cameron, and Willacy counties;
- Nueces and San Patricio Counties;
- Potter County;
- Bexar County; and
- Wichita County.

Services Description

The THV program uses evidence-based home visiting program models to support a variety of outcomes for the services provided to high-risk pregnant women, children, and families. Short term goals include improvement in maternal-newborn health, increase in positive parenting practices, and a decrease in child maltreatment, while long term expectations are focused on improved school outcomes and increased parent self-sufficiency, improved maternal and child health, school readiness and achievement, and coordination and referrals for community resources and supports for families.

In each community, a local contracted organization leads program implementation efforts, working closely with diverse local and state-level stakeholders. All MIECHV programs are required to adhere to national program model standards and are monitored for effectiveness and efficiency using both national and HHSC standards. Communities implement a combination of evidence-based home visiting program models to serve families in targeted areas. These include:

- Early Head Start Home-Based Option,
- Home Instruction for Parents of Preschool Youngsters,
- Nurse-Family Partnership®, and
- Parents as Teachers.

Texas Nurse-Family Partnership

Based on a proven national model, the Texas Nurse-Family Partnership (TNFP) works to improve prenatal and maternal health and social outcomes. S.B. 156 (80-R) authorized the establishment and implementation of Nurse-Family Partnership® (NFP) in Texas. NFP® is a voluntary, evidence-based nurse home visitation program shown to improve the health and well-being of low-income first-time mothers and their children.

Target Population

To be eligible for the TNFP program, women must meet all of the following requirements:

- Enroll in the program voluntarily,
- Have had no previous live births,
- Have an income at or below 185 percent of the federal poverty level,
- Reside in Texas, and
- Enroll in the TNFP program before the end of the 28th week of pregnancy.

Table 5.1, on the following page, gives demographic data for the TNFP population of 5,332 clients at the time of enrollment (at intake) for the time period Sept 1, 2008–June 30, 2013. Thirteen existing state-funded TNFP sites are expected to serve 2,025 clients in 2014. Five existing TNFP sites and two new TNFP sites funded through the federal grant, the THV program, are expected to serve an additional 825 families.

Table 5.1
Characteristics of Texas Nurse Family Partnership Client Population, September 2008 through June 2013

Median Age	19 years
Median Gestational Age, by Week	18 weeks
Race	
American Indian or Alaska Native	0.9%
Asian or Pacific Islander	1.1%
Black or African American	26.4%
White	44.4%
Multiracial	1.8%
No Response/Unknown	25.2%
Ethnicity	
Non-Hispanic or Latina	39.6%
Hispanic or Latina	54.3%
Unknown	6.1%
Married	13%
Median Household Income Range	$6,001–$12,000
Known Employment Status, Part- or Full-Time	
Younger than Age 18	15%
Age 18 or Older	38%
Use of Public Assistance at Time of Enrollment	
Supplemental Nutrition Assistance Program	30.5%
Medicaid	73.9%
Temporary Assistance for Needy Families	3.3%
Women, Infants, and Children Program	70.4%

Table 5.1: Health Policy and Clinical Services, Health and Human Services Commission, 2014.

Services Description

Specially trained registered nurses regularly visit the homes of participating mothers to provide counseling, education, and support through an intensive schedule of visits. TNFP nurse home visitors work with participants to achieve the following four goals:

- To improve pregnancy outcomes,
- To improve child health and development,
- To improve family economic self-sufficiency and stability, and
- To reduce the incidence of child abuse and neglect.

Disaster Assistance Services

Target Population

The Texas Disaster Act of 1975, in conjunction with the federal Disaster Relief Act, authorizes financial grants to individuals and households with disaster-related necessary expenses and serious needs in counties where the United States (U.S.) President has declared major disasters. These needs can include:

- Transportation;
- Personal property; and
- Medical, dental, and funeral expenses.

The program is available to all people who qualify, regardless of race, sex, religion, color, or national origin. U.S. citizens, non-citizen nationals, or qualified aliens in the U.S. may apply, and a parent of a minor child who meets any of these conditions may apply on the minor child's behalf.

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

Service Description

HHSC provides disaster assistance services under the Federal Assistance to Individual and Households Program, which is a federal/state program administered by the Federal Emergency Management Agency and HHSC. The Disaster Case Management Program helps victims of major disasters by:

- Assessing needs based on the verified disaster-related causes,
- Developing a goal-oriented plan that outlines all of the steps necessary to achieve recovery,

- Organizing and coordinating the information on available resources that match the disaster-caused needs,
- Monitoring progress towards reaching the stated goals, and
- Providing advocacy for the client when necessary.

The Emergency Services Program (ESP) distributes available water, ice, and emergency food to the public through shelters and bulk distribution centers, and it provides public access to eligibility services for programs such as the Supplemental Nutrition Assistance Program, Medicaid, and Temporary Assistance for Needy Families. In addition, ESP administers the state Repatriation Program to assist U.S. citizens returning home from a foreign country because of an emergency such as war, threat of war, or natural disaster. Non-emergency repatriation services may also be provided, primarily for unaccompanied children and people with disabilities.

During the past 40 years, Texas has had 58 presidentially declared major disasters, including floods, hurricanes, tornados, severe storms, and fires. Since 1974, expenditures have totaled approximately $770 million in assistance provided to households impacted by disasters. Seventeen major disasters have been declared in Texas since 2001, and the program has aided more than 239,315 households and provided $564 million dollars in assistance.

5.5.2 HHSC Goal 2: Medicaid

This ten-page section gives an overview of the populations Texas Medicaid serves and the services it provides them. For more detailed information, see "Texas Medicaid in Perspective," also known as “The Pink Book,” which may be found on the HHSC website, at www.hhsc.state.tx.us. On the Reports/ Publications page, www.hhsc.state.tx.us/about_hhsc/reports/search/Search_Reports.asp, enter “Pink Book” the title box to see the most recent edition.

Target Population

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people ages 65 and older, and adults and children with disabilities. Initially, the program was only available to people receiving Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI). During the late 1980s and early 1990s, Congress expanded program eligibility to include a broader range of people: older people, people with disabilities, children, and pregnant women.

Poverty-level children comprise the majority of Medicaid recipients but account for a relatively small portion of the expenditures. By contrast, older people and people

with disabilities in 2013 made up just 26 percent of recipients but accounted for 60 percent of Texas Medicaid spending on direct health care services.

As of August 2013, out of a total enrollment of 3,665,263, about 54 percent of those enrolled were female, and 76 percent were younger than age 19. These groups are more likely to meet the eligibility criteria established for TANF, which provides them with automatic Medicaid eligibility. Medicaid eligibility is determined first, and eligibility for other programs is determined subsequently.

Figure 5.3
Medicaid Beneficiaries and Expenditures, Fiscal Year 2013[10]

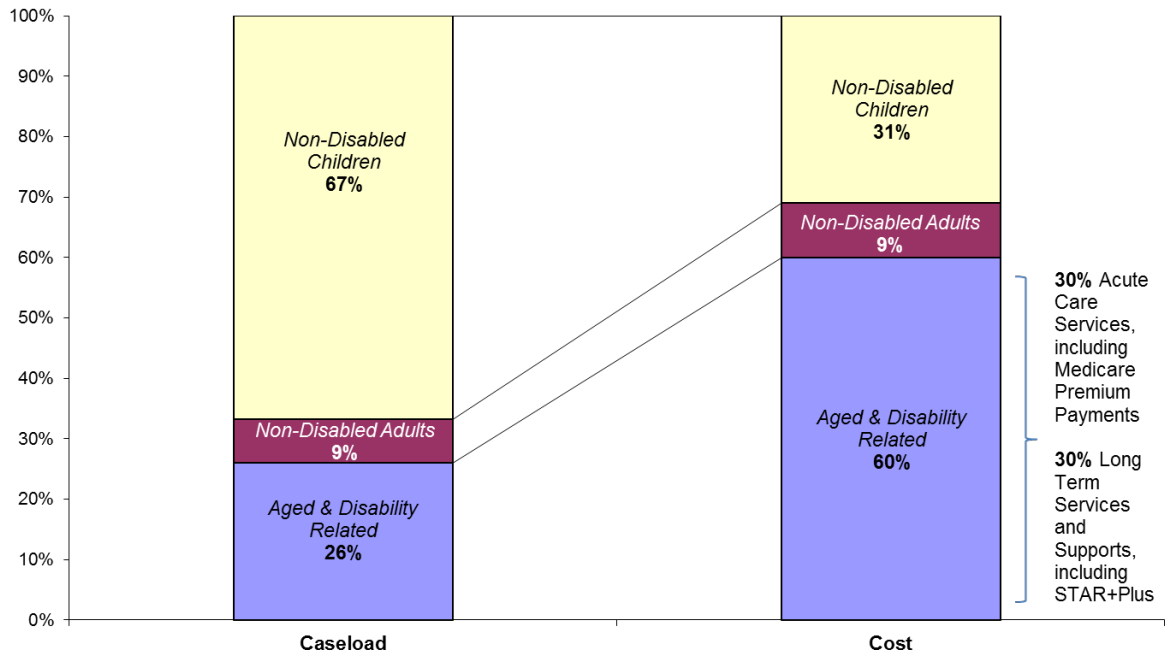

Figure 5.3: Health and Human Services Commission - Financial Services, 2013.

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

[10] Medicaid Client Services Expenditures, including Acute Care, Vendor Drug, and Long-Term Services and Supports. Costs and caseload for all Medicaid payments for full beneficiaries and non-full beneficiaries (Women's Health Waiver, through December 2012, Emergency Services for Non-Citizens, Medicare payments) are included. Children include all Poverty-Level Children ages 0-19. Disability Related Children are in cluded in Aged & Disability-Related.

determination. In Texas, the Department of Assistive and Rehabilitative Services determines disability status on behalf of SSA.

The number of Texans participating in the Medicaid program has increased significantly in the last several years. Figure 5.4 tracks changes in Medicaid enrollment from FY 2006 to FY 2013. During that period, average monthly enrollment in the program grew from 2.79 million to 3.66 million, an increase of approximately 31 percent.

Figure 5.4
Texas Medicaid Enrollment, Fiscal Years 2006–2013

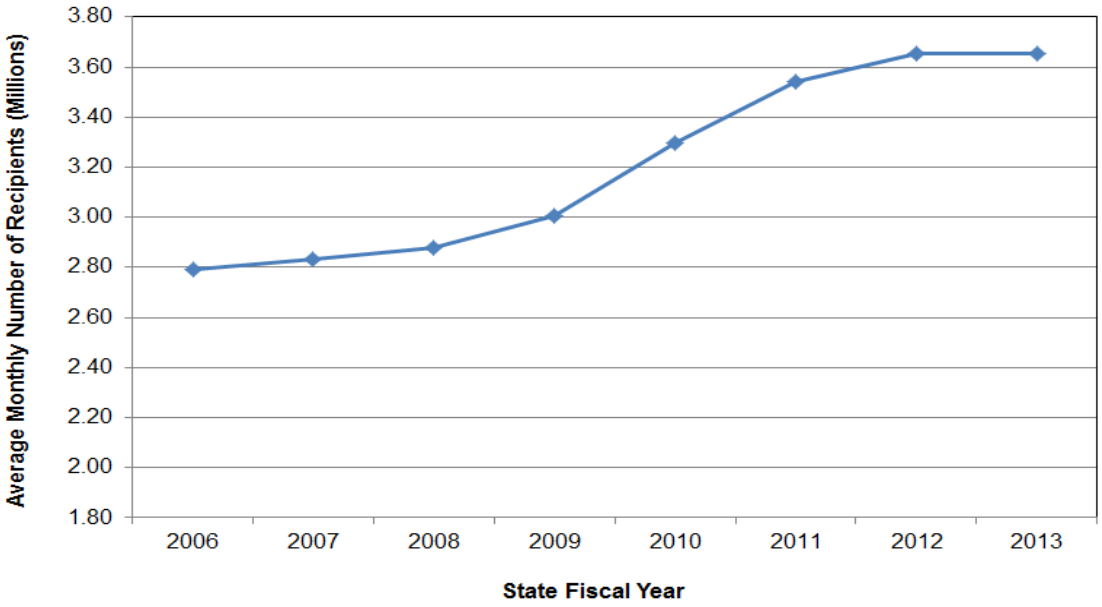

Figure 5.4: Health and Human Services Commission - Strategic Decision Support, March 2012.

The number of Texans in key program categories who could be potentially eligible to receive Medicaid benefits is expected to continue growing. The Medicaid-eligible population is also projected to continue growing from 2015 to 2019.

- The number of qualified pregnant women with income at or below 185 percent of the federal poverty level (FPL) for at least one month of the year is projected to grow from 214,000 in 2015 to 234,000 in 2019, for a 9 percent increase.

- The number of infants at or below 185 percent of FPL for at least one month of the year is projected to grow from 313,000 in 2015 to 338,000 in 2019, for an increase of 8 percent.
- The number of children ages 1 to 5 who are at or below 133 percent of FPL for at least one month of the year is projected to grow from 1,184,000 in 2015 to 1,281,000 in 2019, for an increase of 8 percent.
- The number of children ages 6 to 18 who are at or below 100 percent of poverty for at least one month of the year is projected to increase from 2,383,000 in 2015 to 2,569,000 in 2019, for an increase of 8 percent.

Disability

As of August 2013, 15 percent of the children and adults receiving Texas Medicaid services were eligible because of a disability. However, this figure understates the actual frequency of disabling conditions among Texans in the Medicaid program, because many persons age 65 and older also have a disability.

Gender

As of August 2013, females made up 54 percent of Medicaid clients. Texas Medicaid recipients are disproportionately female, for several reasons.

- Women live longer, on average. In 2013, 56 percent of the population of people ages 65 and older was female.
- TANF beneficiaries are typically single-parent families, and in Texas, 93 percent of single-parent families receiving TANF are headed by females. Additionally, in 2012, 42 percent of single-parent families headed by a female lived below the poverty line, as compared to 8 percent of two-parent families.
- Medicaid covers eligible low-income women for pregnancy-related services.

Age

In August 2013, children younger than age 19 and people ages 65 and older made up 82 percent of all Medicaid enrollees. Children younger than age 19 comprise 76 percent, or 2,772,096 of the 3,665,263 people who were enrolled in the program in August 2013. This figure includes children younger than age 19 who also received SSI benefits due to a disability.

Ethnicity

In August 2013, Hispanics represented the largest proportion of any single race/ethnic group of Medicaid clients, comprising 50 percent of the Medicaid population in Texas, followed by Anglos (19 percent), and then by African Americans

(16 percent). In 2013, the state's population composition according to race/ethnicity was as follows, according to the Texas State Data Center:

- 43 percent Anglo,
- 39 percent Hispanic,
- 12 percent African American, and
- 6 percent all other population groups combined.

Services Description

Medicaid is an entitlement program financed jointly by the state and federal governments and administered by the state. Medicaid pays for acute health care, which includes physician, inpatient, outpatient, pharmacy, lab, and X-ray services. For people ages 65 and older and those with disabilities, Medicaid also covers long-term care services and supports: home and community-based services, nursing facilities, and services provided in intermediate care facilities for individuals with an intellectual disability or related condition. In August 2013, approximately one in seven Texans relied on Medicaid for health insurance or long-term care services and supports, making the Medicaid program the largest health and human services program in the state.

The federal share of the jointly federal-state financed Medicaid program is determined annually based on a formula that takes into consideration the average state per capita income compared to the United State average. This is specifically known as the Federal Medical Assistance Percentage (FMAP) formula. In Texas, the FMAP for the current federal fiscal year (FFY), 2014, is 58.69 percent, a slight decrease compared to FFY 2013, when the FMAP was 59.30. This means that in FFY 2014 the federal government covers 58.69 percent of the cost of providing direct medical services to Medicaid patients.

The cost of administering the program is approximately equally divided between the state and the federal government.

At the operational level, Texas Medicaid provides health care services to most clients through a managed care model that engages multiple organizations/health plans and other programs, as described below.

Managed Care

State of Texas Access Reform (STAR)

Medicaid's State of Texas Access Reform (STAR) program is the managed care program in which HHSC contracts with Managed Care Organizations (MCOs) to provide, arrange for, and coordinate preventative, primary, and acute care covered services, including pharmacy. Separate dental MCOs provide prevention and

medically necessary dental treatment for children. STAR administers services to different eligible populations in different locations.

Effective March 1, 2012, STAR managed care expanded to serve Texas Medicaid clients in 164 rural counties in Medicaid Rural Service Areas (MRSAs). STAR in the MRSAs provides services to the following populations:

- Pregnant women and children with limited income,
- TANF recipients, and
- Adults receiving SSI.

STAR Health

HHSC worked with the Department of Family and Protective Services (DFPS) to develop a medical care delivery system for children in foster care, who are a high-risk population with greater medical and behavioral health care needs than most children in Medicaid, and whose changing circumstances make continuity of care an ongoing challenge. Called STAR Health, the program began in April 2008, serving children as soon as they enter and as long as they stay in state conservatorship. The program also serves youth within two transition categories:

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

Former foster care youth ages 18 and older may choose to receive services through the STAR program rather than STAR Health. Former foster care youth ages 21 through 25 receive coverage in the STAR program.

HHSC administers the program under contract with a single MCO. STAR Health clients receive medical, dental, and behavioral health benefits, including unlimited prescriptions through a medical home. The program also includes a 7-days-per-week, 24-hours-per-day nurse hotline for caregivers and DFPS caseworkers. Use of psychotropic medications is carefully monitored, and in 2010 a trauma-informed care model was initiated, based on best practices for positive outcomes, effectively managing behavior issues that can destabilize children’s health status and foster family placement.

STAR+PLUS

STAR+PLUS is the agency's program for integrating the delivery of acute and long-term services and supports through a managed care system. People who are eligible include SSI/SSI-related recipients with a disability or who are ages 65 and older and have a disability. STAR+PLUS operates in the Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, and Travis service areas. Acute, pharmacy, and long-term services and supports are coordinated and provided through a credentialed provider network contracted with MCOs.

NorthSTAR

NorthSTAR is an integrated behavioral health delivery system in the Dallas service area, serving people who are eligible for Medicaid or who meet other eligibility criteria. It is an initiative of the Department of State Health Services (DSHS). Services are provided via a fully capitated contract with a licensed behavioral health organization. STAR clients in a seven-county area around Dallas receive behavioral health services through NorthSTAR.

Managed Care Expansion

Senate Bill 7 (83-R) continues managed care expansion efforts to other areas of the state by expanding client services and increasing Medicaid populations impacted by managed care. Current managed care expansion activities include the expansion of STAR+PLUS into rural areas and the inclusion of long-term care services and supports as managed care services. Below is a list of current managed care expansion activities.

By September 1, 2014, Texas will:

- Expand STAR+PLUS statewide.
- Enroll individuals who have intellectual and developmental disabilities (IDD) into STAR+PLUS for acute care services only, including:
  - Current STAR IDD individuals who receive long-term services and supports through an intermediate care facility for individuals with intellectual disabilities (ICF-IID) 1915(c) waiver in an MRSA,
  - Individuals who live in a community-based ICF-IID facility located in a MRSA, and
  - Current fee-for-service IDD individuals who receive long-term services and supports in a community-based ICF-IID or through an ICF-IID 1915(c) waiver in the non-MRSA service delivery areas.
- Add supported employment and employment assistance to the STAR+PLUS Home and Community-Based Services waiver statewide.
- Add mental health rehabilitation and targeted case management services to STAR and STAR+PLUS statewide.

By March 1, 2015:

- Add nursing facility services to STAR+PLUS statewide.
- Pending federal approval, add basic attendant and habilitation services for individuals requiring an institutional level of care.

By September 1, 2016:

- Develop STAR Kids program for children with disabilities statewide.

Services for Certain Clients

Texas Medicaid Wellness Program

The Texas Medicaid Wellness Program is a community-based, care-management program that enrolls high-risk Medicaid clients with complex, chronic, or co-morbid conditions. Extensive case management focuses on the whole person, rather than the disease, through telephone and face-to-face interventions that aim to improve health outcomes. The client's care team is led by a registered nurse and includes social workers, community health workers, pharmacists, and behavioral health specialists, among others. In addition to working on the client's care plan with the provider, the care team also assists with transportation and housing issues, medical equipment assistance, and education about disease management and nutrition. Wellness clients also have access to a 24-hour nurse advice line.

Managed Care for Children with Disabilities

Per legislative direction in HHSC's Rider 59 in the 2010–2011 General Appropriations Act (81-R), HHSC began developing a managed care program for children with disabilities to improve the coordination of acute care for current Medicaid recipients. While adult wellness program clients transitioned to managed care, children with disabilities are not a part of the mandatory transition at this time. Therefore, the main focus of the Wellness Program will shift to serving children with disabilities who have SSI or SSI-related Medicaid. Once the program can be evaluated to determine whether it meets the needs of children with disabilities, decisions about future care coordination for children with disabilities will be made.

Texas Women's Health Program

The Texas Women's Health Program is a state-funded program that serves women ages 18 through 44 who are at or below 185 percent of the federal poverty level and meet other eligibility requirements. The program provides preventive health care, screenings, contraceptives, and treatment for certain sexually transmitted infections.

Medicaid for Breast and Cervical Cancer

HHSC's Medicaid for Breast and Cervical Cancer (MBCC) programs provide full Medicaid coverage for eligible uninsured women ages 18 through 64 who have been diagnosed with a qualifying breast or cervical cancer or certain pre-cancer conditions requiring treatment. A qualifying diagnosis is one based on the screening under the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program. To be considered for MBCC, when a woman receives a qualifying diagnosis, from any provider, and her income is at or below 200 percent of FPL, she must go to a Breast and Cervical Cancer Services (BCCS) provider who will screen her for program eligibility. To apply for the BCCS program, a woman must apply through the Breast and Cervical Cancer Services program administered by DSHS. A woman continues to receive full Medicaid benefits as long as she

meets the eligibility criteria and is still receiving active treatment for breast or cervical cancer.

Medicaid Buy-In

HHSC has two programs that promote the health, independence, and productivity of Texans with disabilities. These programs offer Medicaid health care services, including community-based services and supports, at low costs to individuals and families who earn more than Medicaid allows.

Medicaid Buy-In for Workers with Disabilities

In September 2006, HHSC implemented a statewide Medicaid Buy-In program to enable working persons with disabilities to receive Medicaid services. The program is available to individuals with earned income, after applicable deductions, of less than 250 percent of FPL. Medicaid Buy-In clients may be required to pay a monthly premium, depending on their earned and unearned income.

Medicaid Buy-In clients are eligible for the same Medicaid services that are available to adult Medicaid clients, including office visits, hospital stays, X-rays, vision services, hearing services, and prescriptions. If they meet certain functional requirements, they also are eligible for attendant services and day activity health services.

Medicaid Buy-In for Children

In January 2011, HHSC implemented the Medicaid Buy-In program for children up to age 19 who have disabilities and whose family income is less than 300 percent of FPL. Children in the Medicaid Buy-In program are eligible for the same Medicaid services available to children who are enrolled in Medicaid. Children in the program may receive Medicaid through the traditional fee-for-service system or opt into managed care. Families in this program “buy in” to Medicaid by making monthly payments according to a sliding scale that is based on family income.

As a condition of eligibility, federal law requires that a parent enroll in an employer-sponsored health insurance if the parents’ employer offers family coverage under a group health plan and the employer pays at least 50 percent of the total cost of annual premiums. For these families, Medicaid may cover certain services not paid for by an employer.

Medical Transportation Program

Target Population

The Texas Medical Transportation Program (MTP) is responsible for arranging and administering cost-effective, nonemergency medical transportation services to clients of Medicaid, the Children with Special Health Care Needs program, and the

Transportation Indigent Cancer Patients program who do not have any other means of transportation to access medically necessary covered services.

Services Description

- **Mass Transit—**The program provides bus passes or tickets for clients to use fixed-route or inter-city transportation systems. This service is provided under the authority of the State Plan.
- **Demand Response—**Transportation is provided by vendors using buses, vans, or sedans and transportation services offered when fixed route transportation is not available or may not meet the client's needs. Currently, HHSC MTP contracts with 15 Transportation Service Area Providers to provide these services. These services are provided through the authority of a 1915(b) waiver.
- **Mileage Reimbursement—**This option funds reimbursement for a family member, friend or neighbor to drive a client to a health care service. Individuals seeking this service are referred to as Individual Transportation Providers. This service is provided under the authority of the State Plan.
- **Airline Transportation—**Service is provided by a commercial airline for medical care that cannot be provided within the client's transportation service area.

Additionally, clients younger than age 21 may qualify for additional services.

- **Upfront Funds—**Funds are provided when the parent or legal guardian does not have the resources to transport the eligible client to a health care appointment.
- **Meals and Lodging—**These are provided when clients are accessing medically necessary health care services that require overnight or extended stays.

To ensure necessary transportation for clients to and from covered, medically necessary health care services, MTP oversees operation of two transportation service delivery models that comply with federal regulations, are efficient and cost-effective, and meet client needs. Currently, services are provided through a state-operated fee-for-service system, and through two capitated full risk brokers, that provide these services in two specific geographical regions (Dallas/Fort Worth and Houston/Beaumont). Beginning September 1, 2014, the manner in which nonemergency medical transportation will be delivered will change, to improve transportation service delivery to the clients, to contain program costs, and to reduce the incidence of fraud, waste, and abuse. Current and future program administration and contract oversight will be managed by MTP.

The new transportation services delivery model introduces a delivery model that will use managed transportation organizations (MTOs) to provide efficient and cost-effective transportation services in designated regions. MTOs will replace the existing Regional Contracted Brokers and provide transportation services in the newly designated MTO regions, and the current full risk brokers will continue to offer

transportation services in their previously defined service areas. MTOs are defined as:

- Rural or urban transit district,
- Public transportation provider,
- Regional contracted broker,
- Local private transportation provider, or
- Any other entity the commission determines meets the requirements.

The MTOs will provide the same level of transportation services as the current full risk brokers. MTOs must meet the following additional requirements:

- Operate under a capitated rate system;
- Assume financial responsibility under a full risk model;
- Operate a call center;
- Use fixed routes when available and appropriate;
- Agree to provide data to the commission as determined by the commission; and
- Attempt to contract with providers considered to be significant traditional providers, meet the minimum quality and efficiency measures determined by HHSC, and agree to accept the prevailing contract rate of the MTO.

Pursuant to state law, MTOs may own, operate, and maintain a fleet of vehicles or may contract with an entity that owns, operates, and maintains a fleet of vehicles. This statutory provision serves as the basis for HHSC to seek guidance from the federal Centers for Medicare and Medicaid Services on the most appropriate strategy for compliance with federal regulations. To be determined is whether the state should seek a waiver or a State Plan Amendment.

Additional state law authorizes HHSC to enter into agreements for a transit service delivery model performed by qualifying contiguous counties within a managed transportation service region.

5.5.3 HHSC Goal 3: Children's Health Insurance Program Services

Target Population

The Children’s Health Insurance Program (CHIP) assists families who have incomes too high to qualify for Medicaid, but who cannot afford private health insurance. The federal government provides matching funds to states for health insurance coverage for children in families with incomes below 200 percent of the federal poverty level (FPL).

Texas began covering uninsured children from birth through age 19 in CHIP in May 2000. Texas CHIP benefits cover a full range of services, including regular checkups, immunizations, prescription drugs, lab tests, X-rays, hospital visits, and other services.

Enrollment in CHIP increased by approximately 57,500, or 10.5 percent, between September 2011 and August 2013. Total CHIP enrollment in August 2013 was 607,057.

As of August 2013, less than one percent of the 607,000 children enrolled in CHIP were younger than age 1; children ages 1–5 represented 17 percent; and children ages 5 and older represented close to 83 percent.

Coverage of Qualified Immigrants

Texas formerly provided CHIP coverage using general revenue for children who are in the country legally but who are ineligible for Medicaid coverage due to their immigration status. The CHIP Reauthorization Act of 2009 (CHIPRA) discussed below gave states the option of providing Medicaid or CHIP benefits to qualified immigrant children with federal matching funds in both Medicaid and CHIP. In May 2010, Texas began receiving enhanced federal matching funds for the qualified immigrant children formerly covered under CHIP with general revenue and for newly certified qualified immigrant children eligible for Medicaid or CHIP.

CHIP Coverage for Dependents of Public Employees

The ACA allowed the children of public employees to receive federally-matched coverage in CHIP. Texas began providing federally-matched CHIP coverage to qualifying children of employees in the Teacher Retirement System on September 1, 2010, and to former clients of the State Kids Insurance Program on September 1, 2011.

Changes Directed by the Affordable Care Act

Important policy changes are currently impacting enrollment levels in the CHIP program. As required by the Affordable Care Act (ACA) enacted in March 2010, children younger than age 19 with incomes in the 101–133 percent of FPL are categorically eligible for Medicaid starting in fiscal year 2014. Consequently, during the course of fiscal years 2014 and 2015 HHSC will be gradually transferring CHIP enrollees with incomes within that range to Medicaid. In addition, all new applicants with incomes within that range that become eligible will be enrolled in Medicaid. As a result of this policy, HHSC expects that by August 2015 approximately 280,000 children will have been re-directed from CHIP to Medicaid.
Before these changes, the higher proportion of CHIP clients in the older age groups had been due in part to the different income eligibility requirements for CHIP and Medicaid. Traditionally, Medicaid allowed children ages 1–5 to have higher income

limits compared to children ages 6–18. Per the ACA, the Medicaid top income limit for children ages 1–18 is the same.

Services Description

CHIP Reauthorization

CHIPRA authorized CHIP federal funding through FFY 2013, and the ACA extended the program through at least 2015. CHIPRA increased the amount of federal CHIP funding available to Texas and included significant policy changes that have impacted Texas.

For FY 2013, the federal CHIP allotment for Texas was $891.5 million. The CHIP allotment is adjusted annually based upon a formula that takes into account actual CHIP expenditures, child population growth, and a measure of health care inflation. Texas has two years to spend its CHIP allotment.

HHSC has implemented the following policy changes in accordance with federal CHIPRA guidance:

- Requiring CHIP managed care organizations to pay federally-qualified health centers and rural health centers their full encounter rates,
- Applying certain Medicaid managed care safeguards to CHIP,
- Verifying citizenship for CHIP,
- Implementing mental health parity in CHIP, and
- Providing federally-matched CHIP and Medicaid coverage to qualified immigrant children.

CHIP Dental

CHIPRA required all state CHIP programs to cover dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. To comply with this requirement, Texas CHIP dental is required to cover certain services not previously covered, including periodontic and prosthodontic services.

CHIP clients receive up to $564 in dental benefits per enrollment period. Emergency dental services are not included under this cap. Clients are also able to receive certain preventive and medically necessary services beyond the $564 annual benefit limit through a prior authorization process. To offset the costs of covering additional dental services, HHSC raised CHIP cost-sharing amounts.

5.5.4 HHSC Goal 4: Encourage Self-Sufficiency

HHSC administers several programs to encourage self-sufficiency for a variety of populations.

Temporary Assistance for Needy Families

Target Population

The Temporary Assistance for Needy Families (TANF) program provides financial help for children and their parents or relatives living with them who are below the program's eligibility limits for income, budgetary needs, and assets. Many TANF recipients or potential recipients face self-sufficiency issues, especially barriers to entering the workforce, such as lack of affordable child care or reliable transportation. The eligibility limits vary with family size. For example, a single parent with two children must have an unmet financial need of at least $751 per month in order to qualify for TANF. Such a family would qualify for a maximum grant of $277 per month. Assistance is typically provided on a monthly basis, but it may be provided as an emergency cash assistance payment of $1,000, one time per year, if the family meets crisis criteria.

At the end of FY 2013, 35,269 families were participating in the TANF basic program. The number of participating families remained relatively unchanged from August 2009 to August 2011, with the number of participating families averaging approximately 48,000 on a monthly average basis during that period. Due to improved economic conditions over the last several years, the number of participating families has declined. By February 2014 the number of participating families had dropped approximately 30 percent, to 32,327 families, compared to September 2011. It is likely that some families who are eligible for the program are not participating.

Services Description

TANF monthly cash payments help pay for food, clothing, and other basic needs. The primary welfare reform initiative within the TANF program is Texas Works, which encourages people who apply for or receive TANF benefits to find employment. Every adult who applies for TANF benefits is advised of personal responsibility, time-limited benefits, and the requirement to work toward self-sufficiency. The Texas Works program refers applicants to the Texas Workforce Commission, in accordance with current law, for employment and job training services.

The Personal Responsibility Agreement requires a family to comply with requirements about work, child support, school attendance, Texas Health Steps, parenting skills, and refraining from drug or alcohol abuse. If any one of these

requirements is not met, the entire family loses cash assistance, and the caretaker must demonstrate compliance before the family's eligibility can be reinstated.

Supplemental Nutrition Assistance Program

Target Population

The Supplemental Nutrition Assistance Program (SNAP) serves people with food insecurity, a concern for many low-income Texans. The United States Department of Agriculture (USDA) defines food insecurity as inadequate access to food to meet basic needs. The USDA found that during 2010–2012, Texas had the second highest rate of food insecurity when compared to other states, at 18.4 percent, as compared to the national average of 14.7 percent.[11]

The number of SNAP households in Texas increased significantly from 2008 to 2012, partly as a result of the downturn in the economy. In March 2008, Texas issued a total of $236.97 million in food benefits to 2.5 million recipients, and in August 2012, Texas issued $498.2 million to more than 4.1 million recipients. In February 2014, Texas issued a total of $438.8 million to 3.9 million recipients, which represents a 12 percent decline in benefit issuances and an 5.7 percent decline in recipients.

In January 2000, Texas began outreach efforts for the Simplified Nutrition Assistance Program Combined Application Program for older recipients of Supplemental Security Income. The program began in October 2001, adding approximately 60,000 eligible people to the SNAP program. In January 2014, there were 111,709 cases in this program.

Services Description

SNAP is a federally funded entitlement program that helps low-income families buy nutritious food from local retailers. SNAP benefits are 100 percent federally funded and administrative costs are 50 percent federally funded.

2-1-1 Texas Information and Referral Network

Target Population

The 2-1-1 Texas Information and Referral Network (2-1-1 TIRN) makes its services available to the entire population of Texas.

[11] United States Department of Agriculture, Economic Research Service, "Statistical Supplement to Household Food Security in the United States in 2012," Administrative Publication No. (ERR-155) 41 pp, September 2013.

Services Description

The 2-1-1 TIRN is a service for the public to access accurate, well-organized, and easy-to-find information from more than 10,000 state and local health and human services programs via phone or by Internet. Anyone may dial 2-1-1, 24 hours per day, 7 days per week, to receive referrals to health and human services on the local, regional, state, and national levels.

2-1-1 TIRN has established a service level agreement that 80 percent of calls will be answered in 60 seconds or less. In 2013, 2-1-1 TIRN handled more than 3.2 million calls for comprehensive information and referral, with an average of about 269,000 calls per month. The website received about 688,000 visits.

Office of Immigration and Refugee Affairs

Target Population

Texas remains among the top states in number of refugee arrivals. The state received 10,298 refugee arrivals in FY 2013, not inclusive of every refugee who originally resettled in another state and then moved to Texas. HHSC administers the Office of Immigration and Refugee Affairs (OIRA), which provides refugee services for all who meet all requirements of 45 Code of Federal Regulations 400.43.

In addition, persons granted asylum are eligible for refugee benefits and services from the date that asylum was granted. Victims of trafficking and their immediate family members who have received a certification or eligibility letter from the Office of Refugee Resettlement (ORR), at the United States (U.S.) Department of Health and Human Services, are eligible from the date on the certification letter.

Services Description

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

During FY 2013 OIRA provided 14,556 clients with services that included refugee-specific cash and medical assistance benefits and social services.

There are six OIRA program components.

- **Refugee Cash and Medical Assistance programs** serve refugees and other eligible populations who have lived in the U.S. for eight months or less.
  - **Refugee Cash Assistance (RCA)** serves refugees who meet eligibility criteria. RCA is a public/private program administered by refugee resettlement non-profit agencies, whose staff determines eligibility under the OIRA federally approved state plan.
  - **Refugee Medical Assistance (RMA)** serves certain refugees who are ineligible for Medicaid, offering them medical assistance. RMA eligibility and benefits are provided by regional HHSC Centralized Benefits Services staff.
- **Refugee Social Services** include employment services, education services, case management services and other support services, which contribute to economic self-sufficiency and social adjustment. Refugees who have lived in the U.S. for five years or less receive a majority of these services.
- **Special Discretionary Grants** provide specialized services for specific refugee populations and are available to until refugees attain U.S. citizenship. Currently, these grants target services for older refugees, single refugee parents, Cuban arrivals, and refugees of school age.
- **The Unaccompanied Refugee Minors Program** provides foster care and child welfare services for refugee children who arrive in the U.S. without parents or other relatives. HHSC contracts with the Department of Family and Protective Services to provide services.
- **The Refugee Health Screening Program** provides health screenings services for all newly arriving refugees through local health departments. The program screens refugees for health problems and conducts follow-up services for treatment. HHSC contracts with the Department of State Health Services to provide services.

Family Violence Program

Target Population

The Family Violence Program (FVP) serves victims of violence who have been physically, emotionally, and/or sexually abused by a family or household member.

In state fiscal year (FY) 2013, the total number of adults and children who received services from 24-hour-a-day residential and non-residential family violence shelters was 76,244. Of this number, 28,764 were children. Additionally, 199,005 hotline calls were answered by family violence shelters in FY 2013. These survivors of family violence stayed in shelters a combination of 657,000 nights, with an average length of stay of 26 days. There were an additional 10,896 survivors who were not served due to a lack of shelter space.

The lack of access to emergency shelter, transitional and affordable housing, and affordable child care make it difficult for a victim to leave the relationship. Additionally, economic instability and immigration issues are leading causes of victims remaining in shelters longer. Residential and non-residential centers are facing clients with more complex issues related to mental health, substance abuse, and physical and mental disabilities which require more intensive and specialized services and resources. Many providers of family violence services have indicated a need to develop capacity in these areas and in working with people of different socio-economic backgrounds, including immigrants, and senior citizens. There is also an increased need for services for children who have witnessed and/or been direct victims of family violence. These children may exhibit atypical child behaviors such as low self-esteem, high aggression, and isolation.

Services Description

FVP promotes self-sufficiency, safety, and long-term independence from family violence for adult victims and their children by providing emergency shelter and/or support services to victims and their children, educating the public, and providing training and prevention support to various agencies.

FVP contracts with non-profit organizations to provide direct services to victims of family violence. These services fall under three categories: shelter centers, non-residential centers, and special non-residential projects. Since its beginning as a pilot project, the FVP has grown from six shelter centers in 1979 to a total of 68 24-hour- a-day shelters, 10 non-residential centers, and 16 special non-residential projects in FY 2013.

Community Education and Application Assistance Services

Target Population

These programs target people who are potentially eligible for state and federal benefit programs and who are seeking assistance in applying for services.

Services Description

HHSC partners with community-based organizations across Texas and contracts with a statewide network of food banks to help potential and existing clients access SNAP, TANF, the Children’s Health Insurance Program (CHIP), Children's Medicaid, and other programs administered by HHSC. Working with a variety of organizations that provide services at the local level helps ensure that Texans in need of HHSC programs are served in the most convenient and efficient way possible. The state’s size presents a number of challenges to individuals trying to connect to social services. By partnering with community-based organizations, HHSC strives to remove these challenges and help Texans access services. In addition, these

organizations promote use of YourTexasBenefits.com, which supports HHSC's goal of increasing client self-sufficiency through self-service features.

Alternatives to Abortion

Target Population

Alternatives to Abortion serves pregnant women by offering options to support and encourage childbirth. Services are provided at 56 sites across the state. More than 18,150 women received services in FY 2013.

Services Description

The Alternatives to Abortion program provides pregnant women with pregnancy and parenting information and support. The program contracts with the Texas Pregnancy Care Network to provide services at no charge to clients. Clients can continue to receive these services until the child is age one. Currently, the Alternatives to Abortion program has 35 providers with 56 sites throughout Texas.

Comprehensive services include the following:

- Information regarding pregnancy and parenting (brochures, pamphlets, books, classes, and counseling);
- Mentoring program (classes on life skills, budgeting, parenting, stress management, counseling, and General Educational Development);
- Referrals to existing community services and social service programs (child-care services, transportation, low-rent housing);
- Material goods for pregnant women (car seats, maternity clothes, infant diapers, formula); and
- Support groups in maternity homes.

Healthy Marriage Program

Target Population

The goal of the Healthy Marriage Program (HMP) is to increase the well-being of Texas children by providing marriage and relationship education to their parents and to interested couples or individuals. Service recipients may include engaged couples, married couples, and singles. HMP is working to ensure that comprehensive services are available in all counties in Texas.

Services Description

HMP works through a volunteer partnership of public, private, community, and faith-based organizations and leaders to build awareness and provide relationship education and support.

The program components of the HMP for FY 2013 include the:

- Twogether in Texas service network and web portal, and
- Technical assistance for participants and providers.

In FY 2013, there were more than 2,600 volunteer service providers. Some free services are available to all Texans through these volunteer community and faith-based providers. Volunteers can enroll as Twogether providers if their curriculum meets the legislative requirements. All providers appear in the Twogether portal. HHSC maintains the Twogether website and provides operational support for the program.

5.5.5 HHSC Goal 7: Office of Inspector General

Target Population

The Office of Inspector General (OIG) serves the State of Texas by improving the integrity, efficiency, and effectiveness of the HHS System. Specifically OIG interacts with the following groups:

- Health and Human Services (HHS) System employees,
- Managed care organizations,
- Contractors and subcontractors,
- Providers and their staff, and
- Recipients and beneficiaries of health and human services.

Services Description

The 78th Legislature created the OIG in 2003 to strengthen HHSC's authority and ability to combat waste, abuse, and fraud in HHS programs.

Authorized by Section 531.102 of the Texas Government Code, OIG is responsible for the prevention, inspection, audit, review, detection, and investigation of waste, abuse, and fraud in the provision of all HHS programs. OIG fulfills its responsibility through a variety of activities:

- Recommending policies that enhance the prevention and detection of waste, abuse, and fraud;

- Providing education, technical assistance, and training to promote cost-avoidance activities and sustain improved relationships with providers;
- Conducting criminal background checks on providers seeking to enroll or re-enroll in Medicaid, as well as on-site visits for moderate and high-risk providers;
- Auditing and reviewing the use of state or federal funds, including contract and grant funds administered by a person or state entity receiving the funds from an HHS agency;
- Researching, detecting, and identifying events of waste, abuse, and fraud to ensure accountability and responsible use of resources;
- Investigating criminal allegations of abuse, neglect, and exploitation at State Supported Living Centers and State Mental Health Hospitals;
- Conducting investigations and reviews and monitoring cases internally, with appropriate referral to outside agencies for further action; and
- Issuing sanctions and performing corrective actions against program providers and recipients, as appropriate.

Recent Initiatives

OIG takes a variety of proactive measures aimed at preventing fraud, waste and abuse in HHS programs. This includes providing education, technical assistance, and training to providers and other stakeholders in various formats, including written communications, face-to-face trainings, as well as web and social media postings. These efforts cover a wide variety of topics, including:

- Procedures for payment holds and overpayments;
- Frequently asked questions for providers undergoing OIG audits or reviews;
- Guidance on the prohibition of solicitation or offering gifts or other inducements to beneficiaries;
- The correct protocol for providers who want to self-disclose an overpayment;
- Consumer alerts on potential scams; and
- How to report suspected fraud, waste and abuse.

In addition, OIG is working with the Department of Aging and Disability Services to host a series of stakeholder meetings in 2014 that will engage stakeholders regarding the nursing facility utilization review process.

In fiscal year 2013, OIG established a new Managed Care Unit (MCU). The MCU makes recommendations to HHSC's division for Medicaid and the Children’s Health Insurance Program for revisions to the Uniform Managed Care Contract, the Uniform Managed Care Manual, and encounter and claims-related systems, that may impact OIG's efforts to prevent, detect, and investigate potential fraud, waste, or abuse. The MCU also provides specialized assistance to other OIG units in matters of data and workflow analysis, research, reviews, audits, investigations, and cross-functional special projects relating to Medicaid managed care program integrity.

Another new initiative in fiscal year 2013, was the creation of a Data Analytics and Fraud Detection unit within OIG's Enforcement Division. This unit works closely with the vendor OIG has selected to provide graph pattern analysis and intelligence. Through the contract, OIG has deployed a highly advanced graph pattern analysis technology that allows OIG to detect hidden relationships in cyber, intelligence, and financial transactions with the goal of identifying fraud and other aberrant practices. This new technology plays a pivotal role in the Enforcement Division's investigative activities by providing critical intelligence and data analysis.

OIG continues to hire the additional full-time equivalent positions that were authorized and funded by the 83rd Legislature to address OIG's growing and increasingly complex caseload. This new staff includes a medical director and a dental director, who have both been engaged to provide subject matter expertise and consultation on OIG cases.

Chapter 6

Department of Aging and Disability Services Strategic Plan 2015–2019

6.1 Overview

The Department of Aging and Disability Services (DADS) provides a continuum of long-term services and supports (LTSS) 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 6 (79-R) transferred the Guardianship Services program from the Department of Family and Protective Services to DADS, effective September 1, 2005.

The biennial strategic planning process gives DADS an opportunity to assess those issues affecting the accomplishment of its mission.

The remainder of this chapter is arranged as follows:

- Mission,
- External Challenges and Opportunities,
- Internal Challenges and Opportunities, and
- Agency Goals: Target Populations and Services Descriptions.

6.2 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.

6.3 External Challenges and Opportunities

6.3.1 Ensuring the Health and Safety of Aging Texans and Persons with Disabilities Receiving Residential Services and Supports in Institutional and Community Settings

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

- Emphasize health promotion, disease prevention, early intervention, and primary care, in a quality-oriented, electronically enabled, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Improve access to effective services across systems for behavioral health, including prevention, treatment, and recovery services, and integrate physical and behavioral health services.

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

- Ensure the safety and well-being of Texans in facilities regulated by, operated by, or provided via contract with the state, as well as those served in their homes.
- Create a regulatory environment that fosters the health, safety, and opportunities of Texans while ensuring a pro-business approach that supports accountability and innovation.

Discussion

State Supported Living Centers

One of the most critical challenges DADS faces is to ensure the health and safety of individuals with disabilities who receive services in the State's 12 State Supported Living Centers (SSLCs), the Rio Grande State Center, and in homes and communities through contracted residential and community services providers.

Texas continues work to comply with provisions of the state's settlement agreement with the United States (U.S.) Department of Justice (DOJ) to make needed and sustainable improvements to the SSLCs.

Regulatory Oversight and Accountability

Furthermore, the agency's regulatory function ensures compliance of adult day care facilities, assisted living facilities, home and community support services agencies, intermediate care facilities for individuals with an intellectual disability, and nursing facilities (NFs). DADS also monitors compliance with provider contracts.

Evidence-Based Interventions

On a broader level, DADS continues to provide support for a variety of evidence-based interventions designed to promote better health, reduce hospital readmission rates, and support family caregivers. At the local level, Area Agencies on Aging and Aging and Disability Resource Centers choose the interventions they identify as most valuable to their local community so the types of interventions available vary from region to region. These evidence-based programs further assist in diverting individuals from NFs and reducing hospital readmissions.

Planned Actions

State Supported Living Centers

DADS is developing an outcome-based Quality Improvement (QI) Program to assess and improve the quality of care and supports provided to individuals residing in SSLCs and to individuals who have transitioned to a community setting. The goal of the program is to ensure that all services and supports for individuals are of good quality, meet individuals' needs, and help individuals achieve positive outcomes. Goals include protection from harm, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships). Elements of the proposed QI Program include:

- Data verification and evaluation to identify and respond to trends;
- Setting statewide and center-level program goals and benchmarks;
- Providing statewide quality oversight and on-site review;
- Tracking and trending of quality outcomes based on domains of care;
- Care management planning for individuals who reside in SSLCs and who have transitioned from an SSLC to a community setting;
- Physical and behavioral health hotlines available to individuals, their families, and their caregivers/providers to contact for support for the first 12 months following an individual's transition from an SSLC into the community;
- Implementation of an electronic health record/electronic life record; and
- Annual quality of care analysis and reporting at both the SSLC and state levels.

DADS will contract with an external vendor to track physical and behavioral healthcare outcomes for individuals residing in SSLCs and to develop annual quality of care reports. The quality of care reports will demonstrate how the quality of physical and behavioral health care in the Texas SSLC system compares to similar settings and populations nationwide. The reports will also track healthcare outcomes for each SSLC and show how health outcomes compare between SSLCs.

Activities are underway for the QI Program, and all components of the QI Program are expected to be in place by the end of calendar year 2016, when the electronic health record/electronic life record is implemented.

The Money Follows the Person (MFP) Demonstration, considered to be one of the most successful in the country, is a national long-term services and supports rebalancing initiative to help states enhance their community-based system to allow individuals a choice in where they want to live. A pilot project funded via the MFP Demonstration in coordination with three local intellectual and developmental disabilities authorities (Austin-Travis County Integral Care, Bluebonnet Trails Community Services, and Hill Country Mental Health and Developmental Disabilities Centers) is underway to assist individuals living at Austin SSLC who are interested in moving to the community. This project will serve these individuals by:

- Giving them in-depth information about community resources,
- Enhancing opportunities for them and their families to visit potential community resources, and
- Providing intensive support to those individuals leaving Austin SSLC who need such support to achieve success in a community setting.

Regulatory Oversight and Accountability

During the 2015–2019 planning period, DADS will develop and implement a regulatory structure to provide oversight of Prescribed Pediatric Extended Care Centers (PPECCs). Senate Bill 492 (83-R) authorized the regulation of PPECCs to serve medically dependent or technologically dependent minors who, because of an acute, chronic, or intermittent medically fragile or complex condition, require on-going nursing services or routine use of a medical device prescribed by a physician to avert death or further disability. PPECCs are required to hold a license beginning January 1, 2015.

Evidence-Based Interventions

DADS will continue to support evidence-based interventions through the Quality Monitoring Program, the delivery of in-service trainings and conferences, and the dissemination of best practice educational materials and tools. The nurses, dietitians, and pharmacists of the Quality Monitoring Program conducted 3,580 visits to NFs in state fiscal year 2013 and delivered 621 in-services. Approximately 33.4 percent of Medicaid-certified NFs participated in in-services on best practices. Best practice information and resources are available on the DADS Texas Quality Matters website.

6.3.2 Coordinating, Expanding, and Improving Services and Supports to Meet Increased Demand and Changing Profile of Aging Texans and Persons with Disabilities

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

- Improve access to effective services across systems for behavioral health, including prevention, treatment, and recovery services, and integrate physical and behavioral health services.

Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.

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

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Discussion

The demand for long-term services and supports (LTSS) in Texas continues to grow, and it is influenced by two key trends: the aging of the population and the continuing prevalence of individuals with co-occurring behavioral health needs.

Aging of the Population

As noted in Chapter 3, the population of Texans ages 65 and older is projected to increase from 3.2 million in 2015 to 7.5 million in 2040. Since the prevalence of disability increases with age, the number of Texans with disabilities is also expected to increase. The general population of people with disabilities is projected to increase from 3.4 million in 2015 to 6.5 million in 2040. The population of people younger than age 65 who have disabilities is projected to increase from 2.1 million in 2013 to 3.2 million in 2040. The population of people ages 65 and older who have disabilities is projected to increase from 1.3 million in 2015 to 3.2 million in 2040.

As area agencies on aging serve people ages 60 and older, it is important to consider the impact of the growth of this segment of the population in Texas. In 2010, according to the United States Census Bureau, 3.8 million people in Texas were age 60 or older, comprising about 15 percent of the total state population. Between 2010 and 2050, Texas' population of people age 60 and older is projected

to more than triple to 12 million, or 22 percent of the state's population. Texas area agencies on aging can anticipate an increasing need for health and human services, preventive and wellness services, accessible and safe housing, transportation options, and employment opportunities, as well as an increasing need for volunteer and community engagement activities. Because this demographic is so great, caregiver support, prevention and promoting health, making communities more accessible for persons with disabilities, and making communities safer to prevent injury and potential disability are key as cost saving strategies for aging services and programs.

Looking only at the next ten years, demographers estimate that the number of Texans ages 65 to 74 is estimated to increase by about 51 percent. Likewise, the population of individuals ages 60 and older who have intellectual disabilities will also increase substantially. Such significant increases in DADS' target populations are likely to result in similar increases in utilization of DADS programs and services.

The aging of the population will also bring with it a decline in the availability of informal supports. While the current generation of people older than 75 is likely to be the parents of the baby boomers and often has multiple children, the baby boomers themselves have fewer children, are more often childless, and are less likely to be married. Any of these factors could reduce the numbers of those who may be available to provide informal supports.

Addressing Behavioral Health Needs

The incidence and diagnoses of behavioral health issues is increasing for persons with physical and intellectual/developmental disabilities and people who are older. Nearly two thirds of the overall population of the State Supported Living Centers (SSLCs) had a dual diagnosis (co-occurring intellectual disability and a mental illness) in 2013, as did almost 78 percent of those individuals who were admitted to the SSLCs in 2012 and 2013. Nearly 34 percent of individuals across all DADS waiver programs in 2013 had a dual diagnosis. The percentage was even higher for individuals in certain waivers, such as in the Home and Community-based Services waiver, where 36 percent had a dual diagnosis in 2013.

Challenges associated with having a behavioral health diagnosis can limit an individual's ability to become fully integrated in the community. The more capacity that exists in the community system to serve individuals with behavioral health needs, the less likely it is that those individuals will require institutional services, and the easier it will be for these individuals to remain in or transition back to the community.

Increased Demand for Waiver Services

When an individual seeks Medicaid waiver services and a slot is not available, the person is placed on an interest list for that program. The state continues to see

growth in the number of individuals on many of its waiver program interest lists. The monthly average on all interest lists grew from 124,143 in state fiscal year 2009 to 154,538 in state fiscal year 2013, a 24 percent increase. This growth occurred despite significant increases in waiver funding in the 2007, 2009, and 2013 legislative sessions, reflecting the public's increasing awareness of and desire for community-based LTSS.

Planned Actions

Aging of the Population

Federal Funding

DADS, in collaboration with the Health and Human Services Commission (HHSC) and external stakeholders, is addressing these changing needs and this increasing demand through a number of different efforts. DADS and HHSC are currently using and exploring the feasibility of a variety of federal funding options.

- The **Balancing Incentive Program** provides an increase in federal match through September 2015 in return for:
  - Spending more than 50 percent of the state's long-term services and supports appropriation on community services,
  - Ensuring that all the state's assessment instruments cover the same domains,
  - Having conflict-free case management in all its programs, and
  - Establishing a "single point of entry/no wrong door" system for accessing LTSS in local communities.
- The **Community First Choice Program**, currently being considered for implementation in Texas, provides an increase in federal match in return for expansion of the state plan entitlement attendant care/habilitation benefit to a wider population.
- The **Medicare/Medicaid Dual-Eligible Shared Savings Program** allows the state and federal government to share in savings generated through increased coordination of Medicare- and Medicaid-funded services.

Intellectual and Developmental Disabilities Services System Redesign

Senate Bill 7 (83-R) requires the redesign and implementation of the system for delivering acute care and LTSS to individuals with intellectual and developmental disabilities (IDD) using managed care. Several stakeholder committees will be created to advise the DADS on various aspects of the bill. DADS must develop and implement a comprehensive assessment instrument and resource allocation process to be used to recommend services for individuals with IDD enrolled in waiver programs or intermediate care facilities for individuals with an intellectual disability.

Addressing Behavioral Health Needs

DADS is working to improve services for individuals with behavioral health conditions in its programs. Current initiatives are as follows.

- Positive Behavior Management Workshops, which are funded by the Money Follows the Person Demonstration, are held across Texas every year for caregivers, professionals, and all others who work with individuals who have intellectual disabilities who engage in challenging behavior. These workshops are designed to help participants learn evidence-based best practices for prevention and management techniques to support positive behavior.
- DADS is piloting a program which provides and monitors intensive transitional services for individuals with high behavioral needs who are moving from the Austin SSLC to the community.
- DADS provides ongoing educational opportunities to long-term care providers on reducing the use of antipsychotics in nursing facilities and promoting alternatives to antipsychotics through its culture change initiative, as described below in section 6.3.5.
- Quality Monitoring Program pharmacists have developed a tool to help nursing facilities monitor gradual dose reduction in their use of antipsychotics.

6.3.3 Expanding Opportunities for Competitive, Integrated Employment for Persons with Disabilities throughout the State

<u>Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.</u>

- Ensure policies and services encourage responsibility, promote self-service options, and improve access to competitive employment for all Texans.
- Partner with people with disabilities, including people with behavioral health issues, in overcoming barriers to full participation in the community and the workforce.

<u>Strategic Priority: Encourage partnerships and community involvement.</u>

- Continue to enhance interagency partnerships, coordination, and information-sharing in addressing clients' complex needs.

Discussion

Many individuals receiving DADS services have expressed an interest in working, but due to a variety of barriers, they have not obtained employment. In addition to

improving quality of life for an individual with disabilities, employment is cost-effective for the individual, for service funders such as DADS and thus for taxpayers. Senate Bill (S.B.) 1226 (83-R) established a statewide employment-first policy and a task force to promote competitive employment opportunities that provide a living wage for individuals with disabilities.

Planned Actions

Customized Employment Project

During the 2015–2019 planning period, DADS is continuing to implement an initiative to increase employment participation of individuals receiving DADS services. To assist with this initiative, since 2007 DADS has been a member of the State Employment Leadership Network (SELN), a cross-state cooperative venture of agencies serving individuals with intellectual and developmental disabilities (IDD). SELN provides the state technical assistance and collaborative opportunities with other states. While SELN focuses on IDD services, DADS initiative includes all individuals receiving services.

The goals of the initiative include:

- Removing disincentives to employment, such as providers' financial incentive to deliver segregated rather than integrated employment services;
- Providing outreach, training, and resources, such as an employment guide;
- Participating in the Employment First Task Force, as required by S.B. 1226 (83-R), and working together with stakeholders on:
  - Crafting an outreach and education plan, targeted at state agency staff and contractors to raise expectations of community employment for consumers with disabilities; and
  - Developing recommendations for the state agencies to implement an employment first policy;
- Coordinating activities with:
  - The Health and Human Services Commission,
  - The Department of Assistive and Rehabilitative Services (DARS),
  - The Department of State Health Services,
  - The Department of Family and Protective Services,
  - The Texas Education Agency, and
  - The Texas Workforce Commission;
- Collecting and reporting employment data;
- Implementing a Money Follows the Person Demonstration Employment Project to provide short-term administrative funds to providers of IDD services that will use funding to enact organizational change to provide individuals with IDD more opportunity to move out of congregate settings and into employment at local places of business; the project is a collaborative effort among DADS, Medicaid

providers, Local Authorities, case management agencies, and individuals with IDD who are receiving services from DADS and DARS; and

- Positioning the State to improve options for integrated competitive employment for persons with disabilities as required under the Americans with Disabilities Act and related court rulings.

State Supported Living Centers

DADS is working to generate more paid work opportunities for individuals who reside in State Supported Living Centers (SSLCs). This effort includes job skills training at the SSLCs, conducting job exploration tours at businesses in the community, hosting and attending job fairs, and working with employers in the community to offer volunteer opportunities for individuals. Individuals who volunteer with businesses in the community build job skills and also develop relationships that may lead to paid work opportunities with those businesses. Additionally, DADS is working to find creative ways to encourage individuals to work, for example, by hosting employment award ceremonies at the SSLCs and recognizing individuals who have been successful in work activities and employment.

In 2014, the Austin SSLC will enter into an employment contract to provide paid work opportunities for individuals in computer and electronic device disassembly and recycling services. This contract is considered a pilot for the Austin SSLC, and, if successful, will likely expand to other SSLCs in the state. The goal initially of this project is to provide services at SSLC work centers, with the potential to expand to an integrated work setting in the community. As DADS continues to work on improving its network with businesses and employers statewide, it is anticipated that more individuals who reside in SSLCs will participate in supported employment in the community and work for more competitive wages.

6.3.4 Improving Local Access to Long-Term Services and Supports

<u>Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.</u>

- Ensure policies and services encourage responsibility, promote self-service options, and improve access to competitive employment for all Texans.
- Assist older Texans and those with disabilities to gain, maintain, and enhance their ability to live independently.

Strategic Priority: Encourage partnerships and community involvement.

- Continue to enhance interagency partnerships, coordination, and information-sharing in addressing clients' complex needs.

Discussion

At the local level, long-term services and supports (LTSS) 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.

State agency staff, local partner agencies, and contractors must continue to work closely with one another to 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 has planned the statewide expansion of the Aging and Disability Resource Center (ADRC) initiative, which began in 2005 as a federal grant from the Administration for Community Living and the Centers for Medicare & Medicaid Services (CMS). ADRCs serve as a “no wrong door” approach to services and include a network of local service agencies that coordinate information and access to public LTSS programs and benefits through various models of single or multiple points of entry. Models include physical co-locations, virtual co-locations, or a combination of the two. The three DADS “front doors” are the primary ADRC partners and include:

- Community Services regional offices,
- Local intellectual disability authorities (also known as local authorities or LAs), and
- Area Agencies on Aging.

ADRCs may also include key partners from the Health and Human Services Commission benefits offices, hospital discharge planners, mental health authorities, independent living centers, and other community organizations. The statewide expansion is scheduled to be complete by September 1, 2014.

Planned Actions

Aging and Disability Resource Center Expansion

DADS is using federal funding opportunities through the Balancing Incentive Program (BIP) to expand the ADRC model statewide as a “no wrong door” system. Eight new ADRCs will be established in September 2014. When BIP funding ends, DADS will pursue funding to sustain the program.

Following full implementation in September 2015, ADRCs will be required to assess the LTSS needs of individuals using an electronic screening tool. Screening results

will be used to assist individuals with system navigation, person-centered planning services, and referrals to public and private LTSS programs to meet individuals' unique needs.

Relocation and Transition Initiatives

Using Money Follows the Person funding, DADS has implemented several projects to assist individuals with relocating to community living. Projects focus on:

- Identifying community living options for patients being discharged from hospitals;
- Using relocation specialists to identify community housing options for individuals currently residing in an institution;
- Using transition specialists to provide additional education regarding community living options to individuals who reside at State Supported Living Centers (SSLCs), their legally authorized representative if applicable, family, and interdisciplinary team member(s); and
- Collaborating with the Texas Department of Housing and Community Affairs to provide outreach to individuals in need of affordable housing in the community.

State Supported Living Center Census Decline

As the SSLC census continues to decline, DADS will examine, on an ongoing basis, how to best serve individuals with intellectual disabilities, at both the SSLCs and in community settings. It is expected that the number of individuals with intellectual disabilities who live in the community will continually increase in the coming years. With this change, DADS will evaluate the feasibility of SSLCs' providing services and supports, such as physical health, behavioral health, respite, and vocational services, to individuals living in the community.

6.3.5 Developing Data-Based Measures of Quality and Value for Institutional and Community-Based Services and Supports for Aging Texans and Persons with Disabilities

<u>Strategic Priority: Improve and protect the health and well-being of Texans.</u>

- Emphasize health promotion, disease prevention, early intervention, and primary care, in a quality-oriented, electronically enabled, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Continue improving the availability of timely and accurate information to support data-driven decision-making, and invest in systems to leverage the state's health information exchange network where appropriate.

Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.

- Ensure policies and services encourage responsibility, promote self-service options, and improve access to competitive employment for all Texans.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.

Strategic Priority: Ensure the integrity of health and human services providers.

- Optimize the prevention, detection, and correction of fraud, waste, and abuse, focusing on high-risk areas.

Discussion

Satisfaction Surveys of Individuals Receiving Services

DADS administers two quality surveys: the Nursing Facility Quality Review (NFQR) and the Long-Term Services and Supports Quality Review (LTSSQR). The NFQR is a statewide process to benchmark the quality of Medicaid-contracted nursing facility (NF) services. The LTSSQR is a statewide biennial survey of approximately 5,900 adults and children receiving services and supports through home and community-based and institutional programs offered by DADS. The purpose of the LTSSQR is to describe the perceived satisfaction and adequacy of long-term services and supports administered by DADS, consumer quality of life, and trends in long-term services and supports over time.

Culture Change Initiatives

Some facilities in Texas and others nationally are implementing culture change initiatives to improve quality of care, including improved health outcomes. “Culture change” in this context refers to service models that are based on person-directed values and practices and that are designed to create an environment of dignity and respect for individuals receiving services by allowing them to participate in determining how their services are provided.

Reduction in Inappropriate Use of Antipsychotic Medication

Psychotropic medications are substances that act on the central nervous system, causing changes in mood, behavior, cognition or consciousness. Antipsychotics, anxiolytics, sedatives, and hypnotics are all examples of psychotropic medications. Psychotropic medications are commonly used to treat sleep disturbances or to manage behavioral and psychiatric symptoms, particularly in residents with dementia.

More than 50 percent of older adults admitted to a NF receive psychotropic medications within two weeks of admission. In one study of older residents with dementia, 87 percent were taking at least one psychotropic medication, and 11 percent were taking four or more. People older than age 65 are at higher risk for adverse effects of psychotropic medications, and the risk increases substantially with aging and polypharmacy.[1] On a state level, Texas is tied with Louisiana with the highest inappropriate antipsychotic medication usage rate in the nation: 27.6 percent.[2]

In May 2012, the Centers for Medicare & Medicaid Services (CMS) began the "Partnership to Improve Dementia Care in Nursing Homes." This multi-pronged initiative involves:

- Reducing unnecessary antipsychotic medication usage in nursing facilities,
- Educating direct care staff on non-pharmacologic management of dementia behaviors, and
- Researching methods used by nursing facilities to reduce antipsychotic medication use.

Planned Actions

Satisfaction Surveys of Individuals Receiving Services

DADS will continue to administer the NFQR and LTSSQR and target evidence-based interventions based on the results of these surveys. DADS will update its best-practice information database for each identified focus area, based on a comprehensive review of relevant literature and the work of nationally recognized experts. The results of the research will be synthesized into structured assessment tools and will be used to disseminate evidence-based best practice information and provide technical assistance to NF management and staff.

[1] Lindsey PL. Psychotropic medication use among older adults: What all nurses need to know. Journal of Gerontological Nursing. 2009 September; 35(9): 28-38.
[2] Centers for Medicare & Medicaid Services. Nursing Home Compare: Official Nursing Home Compare Dataset Q1-Q3 2013 (January 1, 2013 – September 30, 2013). Retrieved 03/20/14. https://data.medicare.gov/data/nursing-home-compare

DADS will continue to conduct face-to-face consumer surveys to obtain information directly from the individuals receiving community-based services and to measure achievement of their goals and aspirations. Depending upon the characteristics of the individuals being surveyed, two different survey instruments are utilized.

Texas is a member of the National Core Indicators (NCI) project developed by the Human Services Research Institute. The NCI project is designed to assist the 22 member states with developing performance and outcome measurement strategies for their programs. The project provides a nationally recognized survey instrument, the NCI Consumer Survey, which was designed specifically for people with intellectual and developmental disabilities. The survey contains multiple questions to calculate specific indicators that are grouped by four different domains: consumer outcomes, system performance, health, welfare and rights, and self-determination.

The second survey instrument Texas uses is the Participant Experience Survey (PES) developed by MEDSTAT Group, Inc. for CMS. The PES was designed to collect information directly from elderly and non-elderly adults with physical disabilities and divides questions into five domains: access to care, choice and control, respect/dignity, community integration/inclusion, and self-determination. The results of these surveys are shared with internal and external stakeholders to identify experiences of the individuals receiving services, to develop intervention strategies, and to assist in program improvement activities.

Culture Change Initiatives

Under the direction of DADS's Rider 30 of the 2014–2015 General Appropriations Act (83-R), Regulatory Services is implementing a person-centered care project pilot to help NFs improve staff knowledge and implementation of resident-centered care practices in several regions of the state. Additionally, DADS amended NF licensing rules regarding Medicaid bed allocation requirements to add a small-house nursing facility waiver.

Reduction in Inappropriate Use of Antipsychotic Medication

A collaborative project among DADS staff, Texas Medical Foundation Quality Improvement Organization (TMF QIO) staff, and other stakeholders is being developed to reduce the inappropriate use of antipsychotic medications in nursing homes, improve pain management in individuals with dementia, increase the use of alternative strategies to manage dementia care, and explain regulatory implications to providers.

The first phase of the project encompasses a day-long training provided around the state during which providers will have opportunities to sign-up for individual assistance and support unique to their facility. During the second phase, this assistance and support will be provided to participating facilities by interdisciplinary

team members such as quality monitoring program staff, TMF QIO quality consultant staff, long-term care ombudsman, regulatory facility liaison staff, and others.

DADS will continue to provide resources and information to support Texas NFs in implementing culture change and decreasing the inappropriate use of antipsychotic medications. Available resources include webinars and conferences, access to DADS liaisons to provide information and understanding of regulation, and evidence-based materials.

6.3.6 Expanding and Equipping the Workforce of Direct Service and Clinical Professionals to Efficiently and Effectively Support Older Texans and Those with Disabilities, Including Support for Informal Caregivers

Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.

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

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.

Discussion

Direct service workers provide an estimated 70 to 80 percent of the long-term services and supports (LTSS) to individuals who are aging or living with disabilities or other chronic conditions. The demand for direct support workers in the U.S. is increasing rapidly due to growth in population, the aging of the baby boom generation, the aging of family caregivers, and an increasing national commitment to the steady expansion of community and in-home services for individuals needing LTSS.

To ensure that older Texans and those with disabilities receive supports and have positive outcomes, DADS is engaged in initiatives to positively impact the challenges of recruitment and retention faced by providers and recipients of home- and community-based services and by the workers themselves.

Texas Lifespan Respite Care Program

Respite services provide temporary relief to informal, unpaid caregivers, often relatives and friends of the individual, from their duties and may be provided in home or institutional settings. The Texas Lifespan Respite Care Program arose from a 2009 federal grant from the Administration on Aging to create an inventory of respite services and best practice tools, to hold forums for providers, and to coordinate outreach and awareness activities aimed at caregivers.

The Texas Lifespan Respite Care Program was established to:

- Update the inventory of respite services in Texas;
- Disseminate training toolkits for caregivers and respite providers;
- Maintain the www.TakeTimeTexas.org website of respite-related resources and information;
- Replicate innovative service models to educate and support caregivers; and
- Provide direct respite services, as funding is made available, for caregivers who are unable to obtain those services through other avenues.

This initiative focuses on caregivers caring for individuals, regardless of age, disability, or healthcare condition, and it specifically focuses on help for caregivers who cannot get respite care through any other program. The initiative includes respite services available through traditional providers, the use of vouchers for families to obtain their own respite care, the use of trained volunteer caregivers, and some emergency respite care.

Planned Actions

Direct Service Workforce Initiative

During the 2015-2019 planning period, DADS will continue the following activities, funded through the Money Follows the Person Demonstration:

- Conduct a report on the survey and evaluation of direct support workers, and
- Develop an on-line training system.

Texas Lifespan Respite Care Program

The Texas Lifespan Respite Care Program will continue to promote the expansion of sustainable respite services. To achieve these goals, DADS will continue to:

- Work with local contractors in partnership with faith-based and volunteer groups to increase the availability of respite services to caregivers of individuals with behavioral health and medical needs; and
- Identify additional funding to provide evidence-based education, training and support activities for caregivers.

6.3.7 Expanding and Enhancing the Use of Technology in Services and Supports for Aging Texans, Persons with Disabilities, and Persons Delivering these Services and Supports

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Encourage communication, teamwork, and innovation.
- Use technology and other means to maximize work efficiency and eliminate costly maintenance and repair on unneeded or underutilized office space.

Discussion

The use of technology can play a significant role in streamlining and facilitating access to long-term services and supports, both for persons in need of services and supports and for those who provide or deliver those services and supports. Senate Bill 7 (82-1) required DADS to streamline service provision.

Planned Actions

DADS, in collaboration with the Health and Human Services Commission, is building a web-based portal that will enable case managers and providers to send and receive individual assessment information electronically. This secure portal will expedite the service authorization process, as it will provide the receiver of service authorization documents immediate access to the information.

6.3.8 Exploring and Identifying Sources of All Types of Funding for Services and Supports for Aging Texans and Persons with Disabilities

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Encourage communication, teamwork, and innovation.

Discussion

Balancing Incentive Program

The Affordable Care Act created the Balancing Incentive Program (BIP),[3] which authorizes $3 billion through September 2015 for all states to increase access to non-institutionally based long-term services and supports (LTSS). States that spend less than 50 percent of Medicaid LTSS funding on community-based LTSS are eligible for a 2 percent enhanced Federal Medical Assistance Percentage (FMAP).

Texas reported to the Centers for Medicare & Medicaid Services (CMS) in February 2014 that, as of that date, the state expended 56 percent of all LTSS monies on community-based rather than institutional services, meeting the goal of the program. This is an increase from 46.9 percent reported to CMS in federal fiscal year 2009. BIP and Money Follows the Person funding is bringing approximately $200 million to Texas within the next two years. The BIP program functionally ends September 30, 2015.

Planned Actions

The BIP requires DADS to make the following changes.

- **No Wrong Door/Single Entry Point System—**Statewide coordinated system that provides information on available services, how to apply for services, referrals, determinations of financial and functional eligibility, or assistance with assessments for financial and functional eligibility.
- **Core Standardized Assessment Instrument(s)—**Standardized assessment instruments used in a uniform manner throughout the state to determine eligibility, identify service and support needs, and inform care plan development. Assessment instruments must address activities of daily living (ADLs), instrumental ADLs, medical conditions/diagnoses, cognitive functioning/memory, and behavior concerns.
- **Conflict-Free Case Management—**Separation of case management and eligibility determination from service provision (e.g., through administrative separation of services and enhanced state oversight).

[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html.

Three of the State's five health and human services agencies are partnering to implement the BIP: the Health and Human Services Commission (HHSC), DADS, and the Department of State Health Services. HHSC delegated BIP implementation and management activities to DADS, which will continue to implement the required conditions of the BIP.

BIP funds will allow DADS to implement many structural changes, including:

- Enhancements to the YourTexasBenefits.com portal,
- Interoperability of the financial and functional eligibility systems,
- Addition of community services slots to waiver programs to allow additional individuals to be served in the community,
- Creation of a new Medicaid community attendant program,
- Increased wages for community-based direct service workers,
- Additional services to existing waiver programs, and
- Increased technological supports.

In addition to the BIP, DADS will continue to pursue funding from other sources, such as grants and community partnerships.

6.4 Internal Challenges and Opportunities

6.4.1 Maintaining Essential Regulatory and State Supported Living Center Staff

Discussion

DADS' ability to recruit and retain a well-trained and highly capable workforce is vital to the effective and efficient delivery of services. As the need for DADS services continues to grow, so do the challenges DADS faces with recruiting. DADS has been challenged with high turnover and an increase in the vacancy rates in various positions such as quality review surveyors, direct support professionals, nurses, psychiatrists, and psychologists.

The shortage of qualified professional applicants affects recruitment for nurses, engineers, architects, and social workers. Shortage of qualified applicants for positions in the State Supported Living Centers (SSLCs) is particularly acute in both urban and rural areas. The DADS' workforce is aging, as 25.3 percent of the workforce is older than age 50, and approximately 15.1 percent are eligible to retire in the next two to three years. As the economy continues to improve and perceived

benefits of working for state government declines, DADS is challenged to fill positions at every level.

The retention of employees also poses a challenge to all state agencies, including DADS. The statewide turnover rate for all state agencies for full-time and part-time classified employees in state fiscal year 2013 was 17.6 percent. Staff turnover for DADS in 2013 was 33.2 percent. However, the turnover at SSLCs was much higher, at 36.6 percent, with direct support professionals having the highest turnover rate, at 46.8 percent. Other positions with high turnover include: registered nurses at 32.4 percent, licensed vocational nurses at 42.7 percent, psychologists at 42.3 percent and direct support professionals at 46.8 percent.

DADS Regulatory Services professional surveyors—nurses, social workers, architects, engineers, and generalists—receive training that provides skills in demand in the long-term services and supports private sector. More and more employees are leaving state employment in favor of careers in less stressful and more lucrative work environments.

To 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. DADS continues to seek innovative ways to recruit and retain employees, with the goal of increasing applicant pools and reducing vacancy rates.

DADS has implemented several management recruitment strategies to increase awareness of job opportunities, in Regulatory Services and at SSLCs, including:

- 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 high schools, colleges, and universities;
- Hosting career fairs;
- Serving as clinical training sites for nurses, dietitians, therapists, psychologists, and social workers;
- Executing contracts with recruiting firms to attract physicians and psychiatrists;
- Pursuing market salary adjustments and offering competitive salaries for certain clinical professions to reduce the use of contract staff;
- 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.

Planned Actions

Regulatory Services Strategies

Regulatory Services has implemented several retention strategies, including:

- Modifying the composition of survey teams in order to reduce the number of shortage positions such as nurses and engineers on the teams while providing additional support to professional staff;
- Relocating survey teams to smaller communities such as Brenham, where DADS can be more competitive for shortage occupations;
- Cross-training staff to meet state and federal survey requirements in multiple program areas in order to relieve stress caused by an influx of complaints in particular geographic or program areas;
- Creating a DADS State Office investigations team, which also allows shifting of staff to meet short-term needs in a particular area and relieves regional staff of some responsibilities, including investigation of legislative complaints; and
- Implementing Magnet Area Training, with the Centers for Medicare & Medicaid Services to bring required surveyor training to Texas, reducing the need for out-of-state travel.

State Supported Living Center Strategies

SSLCs have implemented the following retention strategies:

- Evaluating regional base salary levels and pursuing adjustments as necessary to continue to reduce vacancies and positively impact retention of staff;
- Payment of professional license fees and continuing education programs for employees whose positions require them to maintain a professional license;
- Pursuing merit pay increases for employees who exhibit outstanding performance;
- Granting academic stipends and educational leave to defray educational expenses for employees who are attending school; and
- Shifting resources from one facility to another to achieve parity in staffing levels commensurate with the service level demands of individuals served at that facility, to assure minimum staffing levels are maintained more consistently, and to increase retention.

6.4.2 Addressing Infrastructure Needs

Increasing Capacity of DADS Information Technology Resources

Discussion

The demand for information technology (IT) projects and initiatives to comply with legislative mandates and meet the needs of individuals receiving DADS services continues to increase. This level of demand exceeds the capacity of DADS IT resources in terms of number of staff and technological skills availability. Continued limitations of resources poses an increasing risk to DADS' capacities to:

- To meet future demands,
- To sustain current technology,
- To maintain or improve service levels, and
- To optimize services through technology.

To meet demand for day-to-day production support and new development projects, IT staff capacity is augmented through the use of contractors. The increase in contractor costs, particularly for production support, is difficult to sustain, and it limits availability of funds to take advantage of the Deliverables-Based IT Services contract through the Texas Department of Information Resources (DIR) to initiate new projects.

There is an ongoing need to monitor and promptly address telecommunications and network bandwidth concerns before they become problems. As more and more applications become automated and web-based, and as the Health and Human Services System moves to cloud-based solutions, it is critical to be proactive in providing sufficient bandwidth and response times.

Planned Actions

DADS will continue to work with the Health and Human Services Commission and DIR to address current and emerging bandwidth needs. The Automated Virtual Private Network project updates the network infrastructure and helps maintain bandwidth. DADS will continue to implement a scalable plan for updating infrastructure and increasing bandwidth. This plan includes replacing numerous switches, routers, and uninterruptible power supplies, and increasing the bandwidth at all 12 State Supported Living Centers (SSLCs). DADS will also work to implement electronic health records at the SSLCs, including efforts to increase bandwidth and implement virtualized desktops, tablets, and potentially wireless technology at the 12 facilities.

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

Discussion

SSLCs require stable and reliable telecommunication systems, infrastructure, and IT hardware and software to support emerging needs and applications such as electronic health records and e-prescribing.

Continuing to maintain and update the IT hardware, software, telecommunications equipment, and related infrastructure at the SSLCs will also provide more reliable systems of communication for residents, their families, and SSLC staff. Improved reliability will enable faster problem resolution and less downtime at the SSLCs and help ensure the safety and security of individuals and staff.

Planned Actions

The following projects and initiatives are needed to address critical concerns and problems facing the SSLCs:

- Implementation of additional electronic health record modules and components to enhance the reliability of service documentation and data reconciliation;
- Completion of system improvements to prepare the SSLC system for new technology, including improving latency and bandwidth issues, addressing ongoing infrastructure issues, adding wireless capability, and acquiring additional computers and devices as needed;
- Implementation of the Virtual Desktop Project;
- Environmental and security upgrades for server and equipment rooms;
- Staffing and resource efficiency projects, including the implementation of automated timekeeping and scheduling, the use of wireless scanners for inventory purposes, and on-line claims adjudication;
- Maintenance and expansion of videoconferencing equipment for all SSLCs and at least one state office location; and
- Equipment for business continuity and disaster recovery (e.g., an automated employee notification system with alerts sent to employees' work and personal cell phones, radios, additional cell phones, active sync devices, tablets, or laptops with air cards for remote access).

6.5 Agency Goals: Target Populations and Services Descriptions

6.5.1 DADS Goal 1: Long-Term Services and Supports

Target Populations and Services Descriptions

Community-Based Services

DADS provides an array of community-based services made available through Medicaid entitlements, Medicaid waiver services, the Older Americans Act (OAA), Social Services Block Grant funds, and state appropriations.[4]

Medicaid community-based entitlement services include Community Attendant Services (CAS), Day Activity and Health Services (DAHS) and Primary Home Care (PHC). An entitlement program is one in which the state must provide those services to all individuals who request such services and are determined eligible.

In FY 2013, the average number of individuals per month receiving Medicaid community-based entitlement services by program was as follows:

- CAS—48,029,
- DAHS—1,891, and
- PHC—11,111.

In addition, Medicaid Hospice is a community-based entitlement program providing support to qualified individuals who have a physician prognosis of six months or less to live. In FY 2013, the average number of individuals per month receiving Medicaid Hospice services in a community setting was 771.[5]

While program eligibility criteria for waiver programs are similar to those for the applicable institutional program, the federal government allows states to waive certain requirements (e.g., comparability, eligibility, and statewide availability) and limit the number of individuals served. Medicaid waiver programs are dependent on specific state and federal appropriations. Individuals are placed on a waiver interest list when the demand for services is greater than the number of available program slots.

[4] Note: All figures for the average number of individuals per month receiving community-based services do not include STAR+PLUS managed care, which is managed by HHSC.
[5] In fiscal year 2013, the Medicaid Hospice Program served an average of 6,920 individuals, of whom 771 individuals received hospice services in the community and 6,149 individuals received hospice services in nursing facilities (NFs).

The Medicaid waiver programs managed by DADS include:

- Community-Based Alternatives (CBA),
- Community Living Assistance and Support Services (CLASS),
- Deaf-Blind with Multiple Disabilities (DBMD),
- Home and Community-Based Services (HCS),
- Medically Dependent Children Program (MDCP), and
- Texas Home Living (TxHmL).

The STAR+PLUS model serves older individuals and those who are blind or who have a disability, providing fully integrated acute and long-term services and supports. STAR+PLUS began operating in Harris County in 1998 and has since expanded across the state:

- 2007—Expansion to 29 counties in the Bexar, Nueces, Travis, and Harris service areas;
- 2010—Expansion to the Dallas and Tarrant 13-county service area;
- 2011—Expansion to 9 more counties in the Harris service area, 8 counties in the Travis service area, 14 counties in the Nueces service area, and 8 counties in the Bexar service area, plus a new 11-county service area near Jefferson County;
- 2012—Expansion to 2 counties in the El Paso area, 15 counties in the Lubbock area, and 10 counties in the Hidalgo area. As of March 1, 2012, STAR+PLUS covered all areas of the state, except the Medicaid rural service areas (MRSAs); and
- 2014—Expansion to the MRSAs is scheduled to occur on September 1, 2014.

In FY 2013, the average number of individuals per month receiving services through DADS Medicaid waivers by program was as follows:

- CBA—9,553,[6]
- CLASS—4,671,
- DBMD—150,
- HCS—20,159,
- MDCP—2,291, and
- TxHmL—4,611.[7]

Services funded through the Title XX Social Services Block Grant include Adult Foster Care (AFC), Consumer Managed Personal Attendant Services (CMPAS), DAHS, Emergency Response Services (ERS), Family Care (FC), Home Delivered

[6] The CBA program was administered by DADS in FY 2013 and FY 2014; however, it will transition to HHSC STAR+PLUS on September 1, 2014.
[7] The 82nd Legislature authorized DADS to refinance up to 5,000 individuals into TxHmL from General Revenue funded services during the 2012–2013 biennium.

Meals, Residential Care, and Special Services for Persons with Disabilities (SSPD). Services funded through general revenue include In-Home and Family Support Services for persons with a physical disability.

In FY 2013, the average number of individuals per month receiving other regional and local community-based services, which were funded through the Social Services Block Grant, was:

- AFC—32,
- CMPAS—400,
- DAHS—2,341,
- ERS—12,419,[8]
- FC—5,104,
- Home Delivered Meals—14,556,
- Residential Care—428, and
- SSPD—75.

The Program for All-Inclusive Care for the Elderly (PACE) uses a comprehensive care approach to providing an array of services for a capitated monthly fee. PACE provides all health-related services for an individual, including inpatient and outpatient medical care, and specialty services, such as dentistry, podiatry, social services, in-home care, meals, transportation, day activities, and housing assistance. Services are limited to the Amarillo/Canyon, El Paso, and Lubbock service areas. For FY 2013, the average number of individuals per month receiving PACE services was 1,046.

In 2011, a number of changes were made to the PACE program, including changes to slot allocations. Passage of House Bill 2903 (82-R) expanded the program by providing individuals residing in nursing facilities (NFs) the ability to use the Money Follows the Person initiative to access PACE, and provided individuals being offered STAR+PLUS services the option of accessing PACE, when the PACE site has available slots. DADS's Rider 48 in the 2014–2015 General Appropriations Act (83-R) allows DADS to expand PACE to three additional sites, each serving up to 150 participants, beginning in fiscal year 2015, and to add 96 additional slots at each of the three existing PACE sites.

Aging Services under Older Americans Act

DADS is designated as the State Unit on Aging and as such is the single state agency responsible for administering programs and services under the federal OAA administered by the Administration for Community Living. To ensure the mandates of the OAA are met, DADS allocates funding and administers programs and services

[8] Many individuals who utilize ERS also receive services through the CBA waiver. As the CBA program transitions to STAR+PLUS, the number of individuals receiving ERS services through DADS continues to decline.

through performance contracts between DADS and a network of 28 Area Agencies on Aging (AAAs).

Based upon the local needs of older individuals within their service area, AAAs provide nutrition, in-home, and other support services, as well as services specifically targeted to informal caregivers. A primary function of AAAs is to provide access and assistance services enabling older persons, their family members, and other caregivers to obtain community services, both public and private, formal and informal. Access and assistance services include information, referral and assistance, care coordination, benefits counseling, and long-term care ombudsman services. Services are typically provided as gap-filling or on a short-term basis, while individual or family circumstances stabilize, or until a long-term solution can be put into place.

Although age is the sole eligibility criterion for individuals seeking services under the OAA, the OAA requires AAAs to target services to individuals who are older and:

- Are at risk of institutional placement;
- Have the greatest economic need, with particular attention to individuals of low-income status and individuals in minority populations; and
- Have the greatest social need, including physical or intellectual disabilities, language barriers, and cultural, social, or geographical isolation.

Local Authority Services

Through 39 Local Authorities (LAs), DADS offers state-funded community-based services for individuals with an IDD diagnosis who meet diagnostic and functional need criteria. LAs serve as the point of entry for publicly funded programs for this population. These programs may be provided by public or private entities. LAs provide or contract to provide an array of services for persons with an IDD and assist individuals interested in applying for enrollment into the following Medicaid-funded programs: intermediate care facilities for individuals with an intellectual disability (ICFs/IID), including State Supported Living Centers (SSLCs), and the HCS and TxHmL waiver programs.

The following services are available through an LA:

- Eligibility determination,
- Service coordination,
- Respite,
- Community support,
- Day habilitation,
- Employment assistance,
- Supported employment,
- Vocational training,

- Specialized therapies,
- Behavioral support, and
- Nursing.

These services are provided through state funds, with the exception of some coordination services that receive funds from Medicaid. In FY 2013, LAs across Texas served an average of 7,471[9] individuals per month, excluding waiver services.

Institutional Services

DADS oversees facilities that provide long-term services and supports for individuals who are older and those with disabilities. Nursing facilities provide services for individuals whose medical conditions require the skills of a licensed nurse on a regular basis. ICFs/IID provide long-term services and supports for persons with an ID requiring residential, medical, and habilitation services.

The Nursing Facility Program provides services to meet medical, nursing, and psychosocial needs. These services include habilitation services, emergency dental services, and specialized services. In FY 2013, NFs served approximately 56,232 individuals per month through Medicaid. Also in FY 2013, an average of 5,810 individuals per month had their Medicare Skilled Nursing Facility co-insurance paid by Medicaid.

The ICF/IID program provides ongoing evaluation and individual program planning, as well as 24-hour supervision, coordination, and integration of health or rehabilitative services to help individuals function to their greatest ability. These residential settings range in size from six beds to one hundred, with the majority of individuals served in six-bed group homes. In FY 2013, an average of 5,509 Medicaid-eligible individuals per month received care from community-based ICFs/IID.

DADS operates SSLCs, each certified as an ICF/IID. SSLCs are campus-based and provide direct services and supports for persons with an ID and significant behavioral or medical needs. SSLCs provide 24-hour residential services, comprehensive behavioral treatment services, and health care services, including physician services, nursing services, and dental services. Other services include: skills training; occupational, physical and speech therapies; vocational programs and employment; and services to maintain connections between residents, their families, and natural support systems.

[9] In response to a reduction of nearly $3.3 in general revenue allocated to the LAs, the LA target for GR services was reduced proportionally. This reduction was based on a decision by the State to discontinue allocation of the state match portion of the Medicaid service coordination rate and pay both the state and federal portions of the rate through Medicaid billing.

The 12 SSLC campuses are located across the state: Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio. In addition, DADS contracts with the Department of State Health Services to provide ICF/IID services at the Rio Grande State Center in Harlingen. On May 3, 2013, 3,607 individuals lived in these 13 facilities.

Guardianship Services

The Guardianship Program provides guardianship services for individuals referred by the Department of Family and Protective Services or by a court with guardianship jurisdiction. A guardian is a court-appointed person or entity charged with making decisions for a person with diminished capacity. Guardianship may include overseeing services, arranging for community or institutional placement, managing estates, and making medical decisions. The target population served by the Guardianship Program is defined by statute and is limited to the following groups:

- Individuals ages 65 and older or individuals with disabilities ages 18 to 65, who have been identified by Adult Protective Services as victims of abuse, neglect, or exploitation and who have an indication of incapacity;
- Individuals reaching age 18 who have been in Child Protective Services conservatorship and who are incapable of managing their own affairs due to incapacity; and
- Individuals referred to the program by a court with probate authority under certain circumstances outlined in statute.

DADS provides guardianship services either directly or through contracts with local guardianship programs. In FY 2013, the Guardianship Program served an average of 1,366 individuals per month. Of these individuals, 422 were served by guardianship contractors and 944 by DADS local Guardianship Program staff.

Long-term Services and Supports Initiatives

Electronic Visit Verification

To ensure individuals are receiving the services authorized for their support and for which the state is currently being billed, DADS's Rider 61 in the 2012–2013 General Appropriations Act (82-R) mandated the implementation of electronic visit verification (EVV). The EVV system is a telephone and computer-based system that verifies that service visits are occurring and documents the precise time when provision of service begins and ends.

All providers delivering the following services for individuals are expected to participate in the EVV initiative:

- Personal assistance services and in-home respite in the CBA Program,
- Residential habilitation and in-home respite in the CLASS Program,

- In-home respite and flexible family support services in MDCP,
- Services in the PHC Program as described in 40 TAC §47.3(20),
- Services in the CAS program as described in §47.3(3), and
- Services in the FC services program as described in §47.3(11).

EVV was rolled out as follows.

- March 1, 2010: Piloted in DADS Region 9 (Midland, Odessa, San Angelo, and the surrounding areas).
- February 1, 2011: Expanded to DADS Regions 2 (Abilene, Wichita Falls, and the surrounding areas) and 4 (Longview, Tyler, and the surrounding areas).
- August 16, 2012: Expanded to include DADS Regions 3 (Dallas, Fort Worth, Denton, and the surrounding areas) and 7 (Austin, Waco, Temple, and the surrounding areas).
- November 15, 2012: Expanded to include DADS Regions 5 (Beaumont, Nacogdoches, Jasper, and surrounding areas) and 6 (Houston, Conroe, Bay City, and the surrounding areas).

Statewide implementation of the EVV initiative is planned to coincide with the implementation of EVV by HHSC. In accordance with HHSC's plans for the future integrated enterprise-wide EVV system, DADS is promulgating rules to expand the services impacted by EVV to include nursing services in the CBA and CLASS programs. These rules are anticipated to be effective by June 1, 2014.

Individuals and agencies participating in the Consumer Directed Services option in the services noted above have the option to participate in the initiative but are not mandated to do so.

Texas Direct Service Workforce Initiative

The direct service workforce plays a critical role in the home and community-based system of services for older individuals and individuals with disabilities. Direct service workers (DSWs) provide an estimated 70 to 80 percent of the long-term services and supports to individuals who are aging or living with disabilities or other chronic conditions. DSWs provide a wide range of services, including cooking, assisting with meals, personal care, 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:

- Population growth;
- Aging of the baby boom generation;
- Increasing prevalence of cognitive and developmental disabilities;

- Aging of family caregivers; and
- National commitment to, and steady expansion of, community and in-home services for individuals needing long-term services and supports.

Nationally, demand for home health aides and personal care aides is projected to increase by 70 percent between 2010 and 2020, 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. It is critical to implement strategies to develop, train, and retain large numbers of high quality direct service workers in coming years.

In 2009, HHSC created the Home and Community-Based Services Workforce Advisory Council. To enhance the recruitment and retention of direct service workers, the Council recommended improving pay, benefits, and other aspects of employment. Continuing work on these important issues is overseen by the Workforce Subcommittee of the Promoting Independence Advisory Committee. The subcommittee's priorities continue to include increases in pay and benefits. A statewide survey of direct service worker-related issues was conducted in April 2014 to inform future policy.

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 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 in several ways: eliminating duplication and fragmentation, improving access to local services and supports, and providing the people DADS serves with more choices and opportunities for receiving critical information, resources, and services.

For example, DADS has developed a strong partnership with Kiwanis International. The partnership supports dignity, choice, and wellness through:

- Supporting Aktion Clubs for residents at nine SSLC locations to offer residents the opportunity to improve social skills and leadership qualities and to participate in community volunteer initiatives;
- Promoting DADS resources and programs through local events, statewide conferences, and web links; and
- Encouraging community volunteer support for DADS and the aging and disability network through local club participation and distribution of available resource material.

Another example of VCE's success is the creation of community collaborative initiatives that support health and wellness, volunteerism, and sharing of information and resources. These partnerships may include: city leadership, Mayor's Fitness

Councils, hospitals, YWCAs/YMCAs, parks and recreation departments, institutions of higher learning, and local businesses. These partners collaborate to build local awareness and provide ongoing community programs. These programs work to:

- Provide health and wellness options for community residents (e.g., the DADS Texercise program);
- Promoting volunteer opportunities; and
- Distributing information about local services and supports that are available to older adults, people with disabilities, and their families.

A third example is the strong partnership DADS has developed 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 the DADS Texercise program through ongoing distribution of Texercise educational materials,
- Involving community partners and agencies that serve older Texans in the planning of the program and launch of events, and
- Encouraging public participation with emphasis on the senior population through AAA marketing and free access to the clubs.

Texercise

Texercise is a statewide health program that was developed by DADS to educate and involve older Texans and their families in physical activities and proper nutrition. The program promotes individual activity, community events, and policies that support wellness in all life areas. The Texercise program provides an array of resources to support educational, motivational, and recognition activities that encourage participation in healthy lifestyle habits and help Texans improve their health and enhance their ability to function independently. These resources include the Texercise handbook, exercise DVD, resistance bands, and T-shirts, which are all provided at no cost to participants. DADS also maintains the www.Texercise.com website, which provides additional resources. Texercise program activities will continue through 2015–2019.

6.5.2 DADS Goal 2: Regulation, Certification, and Outreach

Target Populations and Services Descriptions

This section gives an overview of DADS regulatory and quality assurance programs and services.

Regulatory Services

DADS provides licensing, certification, financial monitoring, inspections, complaint and incident investigation, and enforcement. These regulatory functions ensure compliance with state and federal standards for the following:

- Nursing facilities (NFs),
- Adult day care (ADC) providers,
- Assisted living facilities (ALFs),
- Intermediate care facilities for individuals with an intellectual disability (ICFs/IID),
- Home and community support services agencies (HCSSAs),
- Home and Community-based Services (HCS) waiver providers, and
- Texas Home Living (TxHmL) waiver providers.

These functions ensure that individuals receive services that meet minimum federal and state standards of care and are protected from abuse, neglect, and exploitation. The “Regulatory Services 2013 Annual Report” provides data about these DADS services.

The 83rd Legislature, Regular Session, 2013, created a new type of licensed entity called a Prescribed Pediatric Extended Care Center (PPECC). Care in a PPECC allows minors from birth through age 20 with medically complex conditions to receive daily medical care in a non-residential setting. When prescribed by the minor's physician, minors can attend a PPECC up to a maximum of 12 hours per day to receive medical, nursing, psychosocial, therapeutic and developmental services appropriate to the minor's medical condition and developmental status. DADS is developing rules, with a projected effective date of September 1, 2014, governing this new licensure type. The Health and Human Services Commission is developing a rate methodology for PPECCs that are Medicaid providers.

Through licensure inspections, certification and recertification surveys, and complaint and incident investigations, DADS staff determines whether regulated facilities and agencies comply with the federal and state rules appropriate to the services they provide. Surveyor staff determines if providers are meeting the minimum standards and requirements for licensure and certification, identifies conditions that may jeopardize client health and safety, and identifies deficient practice areas. When deficiencies are identified and cited, surveyor staff monitors the provider's plan of correction to ensure areas of inadequate care are corrected and compliance with state and federal requirements is maintained. State licensure and federal certification requirements include numerous enforcement actions that DADS may pursue to encourage providers to correct problems of noncompliance.

By statute, facilities meeting the definitions of NFs, ALFs, ADCs, and privately owned ICFs/IID must be licensed and must comply with all licensure rules to operate in Texas. Publicly operated ICFs/IID, which are those operated by the state or Local Authorities, and skilled nursing units in acute care hospitals must be certified to

participate in the Medicaid program. HCSSAs, which include home health, personal assistance services, and hospice, also fall under the DADS licensing and certification review functions. In FY 2013, DADS regulated:

- 1,218 NFs,
- 1,792 ALFs,
- 6,296 HCSSAs,
- 862 ICFs/IID, and
- 479 ADC facilities.

Additionally, DADS conducts annual, on-site reviews of 737 HCS waiver contracts and 327 TxHmL waiver contracts for compliance with each program's certification principles. Based on the review, corrective actions may be required and sanctions imposed. DADS is responsible for investigating complaints related to HCS and TxHmL services. DADS also receives and follows up on investigations conducted by the Department of Family and Protective Services related to abuse, neglect, or exploitation of individuals who receive HCS, TxHmL, or ICF/IID services.

Of the approximately 3.4 million older Texans and 3.2 million Texans with a disability, DADS has oversight, administrative, and regulatory responsibilities related to the approximately 1.8 million individuals receiving services through the following long-term services and supports programs. In FY 2013, there were approximately:

- 93,700 individuals living in NFs,
- 37,550 individuals living in ALFs, and
- 21,950 individuals receiving services in ADC facilities.

Additionally, there were:

- Approximately 3,650 individuals receiving services in State Supported Living Centers (SSLCs),
- More than 5,500 people in community ICFs/IID, and
- More than 26,500 individuals participating in TxHmL and HCS waiver programs.

It is estimated that approximately 1.2 million individuals received services from a HCSSA during the 2012–2013 biennium.

Licensing and Credentialing Services

When a provider applies for licensure, the division reviews the applicant's history, obtaining detailed information on operators, owners, and other controlling persons. Staff assesses this information and approves or denies the application.

DADS administers four credentialing programs. Through these programs, DADS licenses, certifies, permits, and monitors individuals to determine whether they can be employed in facilities and agencies regulated by DADS. The programs provide a

means of ensuring these health professionals meet specific standards in providing care to individuals receiving long-term services and supports.

The Nurse Aide Training and Competency Evaluation Program is responsible for reviewing and approving or withdrawing approval of nurse aide training courses and skills examinations, and for certifying nurse aides to provide services in DADS licensed facilities. The Nurse Aide Registry Program is responsible for maintaining a registry of certified nurse aides and providing due process considerations and determinations of employability in nursing and other facilities. In FY 2013, there were 138,755 active certified nurse aides.

The Nursing Facility Administrator Licensing Program is responsible for licensing and continuing education activities, imposing and monitoring sanctions, providing due process considerations, and developing educational curricula. In FY 2013, there were 2,194 active NF administrators.

The Medication Aide Program is responsible for medication aide permitting and continuing education activities, permit issuance, and permit renewal. Along with permitting aides, the program imposes and monitors sanctions and provides due process considerations. Other activities include approving and monitoring medication aide training programs in educational institutions, developing educational curricula, and coordinating and administering examinations. In FY 2013, there were 10,565 active permitted medication aides.

Long-Term Care Quality Outreach

The Quality Monitoring Program

Established by Senate Bill 1839 (77-R), the Quality Monitoring Program is staffed with nurses, dietitians, and pharmacists who provide clinical technical assistance to NFs statewide. Staff schedules visits with NFs to review quality in selected focus areas that are directly related to quality of care and quality of life. These currently include topics such as fall risk assessment, pain assessment and management, vaccinations, the use of restraints, dehydration, advance care planning, unintended weight loss, appropriate use of psychoactive medications, and medication simplification. Quality-monitoring staff provides technical assistance and in-service training to nursing home staff, people who live in nursing homes, and their families.

Quality Reporting System

The Quality Reporting System (QRS) is a public, web-based resource used to find and compare providers of long-term services and supports. The website can be accessed at http://facilityquality.dads.state.tx.us/qrs/public/qrs.do. Current provider groups covered on QRS include:

- NFs,
- ICFs/IID,

- SSLCs,
- ALFs,
- ADC providers,
- Home health agencies, and
- Providers of home- and community-based services through Medicaid waiver programs.

Quality Reviews

DADS conducts two customer satisfaction reviews (quality reviews) that include a randomly selected sample of people receiving services. These reports are required by DADS's Rider 13 in the 2014–2015 General Appropriations Act (83-R).

The Nursing Facility Quality Review is a survey of individuals in NFs to assess how satisfied they are with their quality of care and quality of life, and it includes on-site interviews and case reviews. At least one person from every Medicaid-certified NF in Texas is invited to participate. Usually, the reviews include more than 2,000 Texans living in NFs.

The Long-Term Services and Supports (LTSS) Quality Review Report is a biennial statewide survey of children and adults receiving services and supports through DADS programs. The purpose of the LTSS survey is to describe the perceived quality and adequacy of long-term services and supports administered by DADS, consumer quality of life, and trends in long-term services and supports over time. Data are collected on the following broad domains: services satisfaction, systems performance, health and welfare, individual choice and respect, and work and community inclusion.

The results of both surveys are available at www.texasqualitymatters.org.

Aging and Disability Training

DADS has sponsored training for several years on quality-related topics, such as culture change, care planning, infection control, pain management, positive behavior management, dementia, and falls prevention and management. Future training will be developed in collaboration with stakeholders.

In collaboration with the Texas Culture Change Coalition, DADS has hosted symposia on culture change in nursing facilities. The central theme of these training opportunities is person-centered and person-directed care that fully aligns with NF regulations and can be accomplished as a low or no-cost strategy.

Since 2008, DADS has hosted Positive Behavior Management workshops, presented by behavior analysis staff from the University of North Texas Behavior Analysis Research Center. The workshops provide professionals, direct service

staff, and family members with information and tools to support individuals with challenging behavior. Workshops are provided several times a year at various locations around the state.

Per statutory requirements, an ICF/IID training conference is held annually to assist providers in understanding the regulatory requirements of the ICF/IID program, to review deficiencies commonly cited in ICF/IID facilities, and to inform providers of any recent changes in rules or interpretation of rules relating to the ICF/IID program. Approximately 300 participants attended this year's ICF/IID conference, held in February 2014.

Chapter 7

Department of Assistive and Rehabilitative Services Strategic Plan 2015–2019

7.1 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: the Interagency Council on Early Childhood Intervention, the Commission for the Blind, the Commission for the Deaf and Hard of Hearing, and the Rehabilitation Commission.

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. DARS 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 to help Texans with disabilities find jobs through vocational rehabilitation, to ensure Texans with disabilities live independently in their communities, and to help children with disabilities and developmental delays reach their full potential.

The remainder of this chapter is arranged as follows:

- Mission,
- External Challenges and Opportunities,
- Internal Challenges and Opportunities, and
- Agency Goals: Target Populations and Services Descriptions.

7.2 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 enable their full participation in society.

7.3 External Challenges and Opportunities

7.3.1 Developing Vocational Rehabilitation Strategies to Increase Access to Services and Improving Service Delivery to Meet the Needs of Students, Unserved Populations, and Underserved Populations

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

- Improve coordination and accessibility of veterans' health services and employment opportunities, as appropriate, within the health and human services system.

Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.

- Ensure policies and services encourage responsibility, promote self-service options, and improve access to competitive employment for all Texans.
- Partner with people with disabilities, including people with behavioral health issues, in overcoming barriers to full participation in the community and the workforce.
- Support children and youth in health and human services programs to ensure their successful transition into adulthood.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Increasing Vocational Rehabilitation Services to Veterans with Disabilities and Improving Coordination with Other Federal and State Entities Providing Veteran Services

Discussion

Unserved consumers are defined as those who may benefit from vocational rehabilitation (VR) services but are not accessing VR services in proportion to their percentage of the population. The VR program has identified United States (U.S.) military veterans with disabilities as a potentially unserved population. While the VR program currently serves veterans with disabilities, more veterans may benefit from VR services if they were made aware of the services and how to access them. From 2010 to 2014, three percent of all consumers receiving VR services in the Division for Rehabilitation Services (DRS) and Division for Blind Services (DBS) were veterans.

Veterans have unique vocational rehabilitation needs. The trauma associated with an injury received while in active military service and dealing with re-entry into civilian life make adjusting to a disability more difficult. Benefits through the U.S. Veteran's Administration (VA) are not universally available to veterans with disabilities, due to geographic barriers or untimely attempts to access those benefits. In addition, veterans who have a non-service related disability may not be eligible for all of the VA's VR services.

There are numerous programs and initiatives, both public and private, at the state and federal levels that serve veterans. Few of them have employment-specific programs for veterans with disabilities, and fewer still have programs for veterans who are blind or visually impaired. As the veteran population grows, the number of veterans experiencing blindness or vision difficulty will also increase.

Planned Actions

DARS will increase VR services to veterans with disabilities and improve coordination with other federal and state entities that provide services to veterans. DARS will:

- Evaluate policies, procedures, and rules to provide seamless and efficient access to services for veterans with disabilities who are not eligible to receive services from the VA's VR program;
- Enhance coordination with other entities serving veterans with disabilities, to help veterans more easily navigate available programs and services;
- Provide additional resources and training to VR counselors to improve their ability to provide vocational counseling to veterans, including helping veterans identify how to transfer their military occupational skills to the civilian workforce;
- Pilot the use of specialized caseloads, with designated counselors who are better prepared to serve the unique VR needs of veterans, to determine whether increased access and better outcomes result; and

- Increase collaboration with veterans stakeholder organizations and service providers to:
  - Enhance the coordination and provision of services to veterans with disabilities;
  - Increase the number of veterans with disabilities receiving VR services;
  - Enhance communication with veterans communities and identification of veterans in need of VR services; and
  - Better coordinate veterans' services with other agencies within the Health and Human Services System.

Increasing Vocational Rehabilitation Staff Knowledge and Skills with Effective Rehabilitation Strategies for Serving Underserved Consumers

Discussion

Underserved VR consumers are people who have a disability who are eligible to receive services from DARS but are not served as effectively as other DARS consumers. Underserved consumers in this section include people who have:

- Developmental or intellectual impairments,
- Neurodevelopmental disorders such as autism,
- Mental health disorders such as bipolar disorder or schizophrenia,
- Other disabilities in addition to blindness, and
- Deafblindness.

While underserved consumers constitute one third of the DARS Division for Rehabilitation Services (DRS) VR consumers, the successful rehabilitation rate for these consumers is lower than for other DRS VR consumers. Historically, the VR program has focused on serving consumers with physical disabilities. As a result, the DRS VR program developed the expertise and capacity to effectively serve consumers with physical disabilities. People with intellectual, developmental, and mental health disabilities were present in the VR consumer caseload, but in low numbers. The number of underserved consumers has grown steadily in recent years. This growth has occurred for a number of reasons, including an increased focus on public policy initiatives emphasizing community integration rather than institutionalization.

In 2013, 45 percent of VR consumers served by DBS had disabilities in addition to blindness. Additional disabilities, such as intellectual and developmental disabilities, autism, traumatic brain injury, and mental health conditions, impact the number, types, intensity, and length of services required to obtain employment. Characteristics associated with these disabilities, such as a lack of short-term memory or limited communication abilities, become even more difficult to mitigate

when coupled with a sensory disability that separates the individual from the surrounding environment. Staff skills to assist with adapting to the home and employment environment context are required to address these consumers' employment needs adequately and maximize their strengths.

People who are deafblind are challenged in all aspects of their lives. They must develop their ways to communicate, navigate their surroundings, and locate social, living, and employment situations that fit their needs and abilities. Communication and mobility are the two areas most affected by the loss of sight and hearing.

The increase in the number of underserved VR consumers, in combination with the lower successful rehabilitation rate for this population, is why both DRS and DBS must develop a new approach to serving these consumers. DARS will seek to increase staff knowledge and skills with effective rehabilitation strategies for serving people with intellectual, developmental, and mental health disabilities.

Planned Actions

To better serve this population of consumers, DARS will increase staff knowledge and skills with effective rehabilitation strategies for serving consumers who have developmental or intellectual impairments, neurodevelopmental disorders, mental health disorders, disabilities in addition to blindness, and deafblindness. DARS will:

- Research and implement best practices to serve these underserved consumers and to seek stakeholder feedback on solutions and strategies for improving services;
- Increase coordination and develop new partnerships with other state and community organizations that serve people with developmental or intellectual impairments and mental health disorders, to include:
    - Mental health organizations, local authorities, and universities to develop resources, expand knowledge, and implement best practices;
    - The Mental Health Coordination Initiative at the Health and Human Services Commission, to identify and implement best practices, to identify potential community partners, and to facilitate service coordination; and
    - The Helen Keller National Center for Deaf-Blind Youths and Adults; and
- Build staff capacity and expertise through coordination with state and community organizations and the use of internal and external subject matter experts to provide staff training.

Improving the Effectiveness of Vocational Rehabilitation Transition Services by Expanding Partnerships with Schools and Community and Technical Colleges, and Increasing the Availability of Work Experience for Transition Students

Discussion

VR transition services are provided to students with disabilities who are eligible for services under the Rehabilitation Act. The Act defines transition services as "a coordinated set of activities for a student, designed within an outcome-oriented process that promotes movement from school to post school activities." These activities include postsecondary vocational training, integrated employment, continuing and adult education, independent living, and community participation.

At both the national and state levels there is a growing recognition of the need to expand and improve services for transition-age students in schools. Recent Congressional proposals for reauthorization of the Workforce Investment Act of 1998 would require VR agencies to serve more transition students or expand strategies for transition services. For example, some proposals would require developing additional services, increasing the number of transition students served by VR, and increasing VR funds expended for transition services.

In Texas, House Bill 617 (83-R) requires each school district to designate a transition coordinator for students in special education, and Senate Bill 1226 (83-R) establishes competitive employment as the preferred outcome for people with disabilities. This increased focus on transition services will require DARS to expand its capacity to serve transition-age consumers, develop new service delivery strategies, and increase partnerships with secondary and postsecondary education.

Perceptions about the VR program affect DARS' ability to build effective partnerships with some schools. The goals of expansion and improvement would be to increase consistency and coordination in the delivery of VR services and to improve outcomes for transition-age consumers. DRS defines transition-age VR consumers as those who are ages 16 through 24 at application. DARS has 119.5 full-time equivalent transition vocational rehabilitation counselor (TVRC) positions which serve approximately one third of the state's more than 1,400 public high schools. To maximize coverage, DARS also assigns some VR counselors a partial transition-age caseload. Schools with an assigned TVRC have better perceptions about their responsiveness and availability. This is due at least partially to TVRCs' greater visibility and availability than VR counselors, who carry a general caseload of both transition-age and adult consumers and visit their designated high schools only as needed.

VR services offered by schools may vary by school district. DARS cannot duplicate any service provided by the school district, but not all school districts provide the same services. This disparity creates confusion for staff, schools, and consumers.

Understanding career options, developing a work ethic, and gaining work experience are critical for transition-age consumers to succeed in VR and in a work environment. Consumers gain invaluable experience in workplace settings, which helps them learn about job expectations, the work environment, and the skills required to succeed in the workplace. Work experience opportunities also increase employment outcomes for transition-age consumers. Currently, work experience and job shadowing programs have been offered by DARS on a limited basis, primarily through summer employment programs or special projects, and they are only available in a limited number of locales.

Planned Actions

To better serve this population of consumers, DARS will:

- Increase staff knowledge and skills to help consumers more effectively, particularly transition-age consumers with intellectual impairments, autism, mental health disorders, and multiple disabilities, as they transition to postsecondary education and achieving employment goals;
- Evaluate and revise policy, procedures, and staffing strategies to improve consistency and effectiveness in service delivery;
- Enhance collaboration and coordination with the Texas Education Agency, the Texas Higher Education Coordinating Board, education service centers, the Texas Workforce Commission, and local workforce boards and centers to improve access to services and to develop and implement additional service delivery strategies;
- Expand partnerships with high schools and community and technical colleges to improve access and transition for students moving from secondary to postsecondary education and training;
- Expand partnerships with businesses that have an interest in pre-employment training for high school students and develop additional work experience options such as:
    - Summer work programs;
    - Internships, job-shadowing, and on-the-job training opportunities based on the consumer's interest and vocational goals;
    - Career guidance; and
    - Career mentoring and peer- to-peer mentoring programs; and
- Encourage partners to pursue grant opportunities to fund programs that will facilitate successful transitions from school to postsecondary education and work.

Improving Coordination and Enhancing Strategies to Develop and Maintain Business Relationships that Will Result In Improved Quality Employment Outcomes for Vocational Rehabilitation Consumers

Discussion

DARS develops ongoing relationships with businesses who hire VR consumers. DRS and DBS maintain regional points of contact for the nationwide VR network of state VR agencies. In addition, DARS keeps track of regional labor market trends to help in targeting growing businesses and to aid VR consumers in making informed career choices. However, these activities are divided among various staff positions in the DRS and the DBS. These activities could be better coordinated through development of a strategic approach of working with business partners, creating a better database and stronger coordination between DRS and DBS.

Currently, a DARS program specialist for business relations in each region to help the regional leadership and field staff establish partnerships with businesses, develop the field staff's skill sets to understand employer needs, and serve business customers. In addition, one or more VR counselors, supported by the regional program specialist for business relations, often act as the lead staff for certain businesses or industries in a particular geographic area. VR counselors and specialists coordinate with community rehabilitation programs, workforce centers, workforce boards, schools, and other partners to conduct job fairs, develop business partnerships, implement special projects, and participate in a variety of community activities.

Business services at DARS will benefit from an agency-wide approach and shared resources between DRS and DBS. Each division offers services to businesses, and each has designated staff who are dedicated to serving the business customer and to building capacity of field management and staff to serve businesses. Improving collaboration will allow DARS to provide more coordinated services to businesses and more effectively partner with other agencies and community programs that serve employers.

Planned Actions

To improve coordination and enhance strategies for developing and maintaining business relationships, DARS will:

- Improve collaboration between DRS and DBS regarding services to business customers by developing and implementing a joint strategy for serving businesses, and
- Partner with the Texas Workforce Commission to identify best practices in coordinating services to businesses at the local level and promoting replication of those practices.

Increasing the Availability of Technology, Which is Important to Vocational Rehabilitation Consumer Employment

Discussion

Technology can level the playing field for a prospective job applicant with a disability. Businesses often use the latest technology to organize, plan, and achieve success, so it is important for VR consumers to use the same new technologies as their counterparts to fully participate and compete in the workforce.

VR consumers frequently learn from DARS counselors about new and emerging personal assistance technologies that also have the potential to help them in the work environment.

To ensure DARS counselors can continue to effectively assist consumers, DARS staff must maintain knowledge of developments and trends in the field of assistive technology to identify and acquire appropriate assistive equipment for successful employment outcomes. DARS will work to ensure that knowledge and training related to the technology needs of VR consumers in the workplace is available to staff and can be used for optimal case management and consumer outcomes.

Planned Actions

To increase the availability of and consumer proficiency in technology, which is important to VR consumer employment, DARS will:

- Ensure there are adequate current technologies available for consumer use in training situations;
- Make technology available to consumers for use in employment settings;
- Facilitate access to technology in the community for people who are blind or visually impaired, by:
  - Partnering with community organizations to identify people who need technology to obtain or maintain their employment, and
  - Assessing the feasibility of establishing technology resource and training locations within community organizations that are accessible to consumers as well as other people who are blind and visually impaired; and
- Research advances in technology to make sure that VR counselors are aware of and maximize current technology by:
  - Identifying opportunities to obtain current technology information from organizations that develop and access new technology for people who are blind or visually impaired;

- Participating in technology conferences and demonstrations and communicating with technology developers to assess new and updated technology; and
- Facilitating VR counselors' access to current information about technology that would contribute to the positive employment outcomes for VR consumers.

7.3.2 Evaluating the Capacity to Address the Needs of Children Identified as Eligible for Services in the Broader Texas Early Childhood Intervention System

Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.

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

Discussion

The Early Childhood Intervention (ECI) program is required by the federal Individuals with Disabilities Education Act (IDEA) to serve all eligible children younger than age three and provide the intervention services they need to address developmental delays. The program increases the number of children who are school-ready and decreases the intensity of later service needs for children with disabilities and significant delays.

Local ECI programs must be prepared to serve all children who are determined eligible. Due to state and national attention on the importance of screening for developmental delays in early childhood, referrals of children with a suspected developmental delay to ECI is increasing. Of the children eligible because of developmental delays, the percentage of children with delays in multiple areas has increased from 37 percent in 2004 to more than 55 percent in 2010, and to 68 percent in 2012. This increase in referrals will potentially result in caseload growth at a time when local ECI programs are serving a larger number of children with multiple and complex needs.

DARS ECI is part of an integrated system of care for children. Decisions made in this larger system often impact ECI. Conversely, changes to ECI services must be made with an understanding of the potential effects on other components of this integrated system. These influences necessitate development of a strategy to address ECI caseload growth, service needs of children in ECI, and ECI revenue

streams. ECI needs an effective mechanism to respond to the increased demand for services in the integrated early childhood system.

Planned Actions

To evaluate the capacity of ECI to address the needs of children identified in the broader Texas early childhood system, DARS will:

- Continue to collaborate with the Texas Medicaid program for system changes that result in improved outcomes for children, while ensuring adequate funding is available for increased demand for services;
- Work with the Health and Human Services Commission to further develop ECI medical policy and Medicaid rates paid to ECI contractors by exploring specialized rates with the Centers for Medicare & Medicaid; and
- Evaluate the potential to develop cost-based rates for certain required services, which are delivered by a multidisciplinary team, to allow Texas to realize additional federal revenue.

7.3.3 Increasing the Capacity to Meet the Needs of Texans Who are Deaf or Hard of Hearing

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.
- Further expand partnerships with institutions of higher education to foster collaborative efforts and workforce development.

Discussion

DARS estimates there are approximately 900,000 people in Texas who are deaf or severely hard of hearing as of 2012. Based on data from the United States Census Bureau, DARS projects this population will grow to approximately 1,000,000 by 2017. As of March 2014, there are 1,500 interpreters for the deaf certified by the Board for Evaluation of Interpreters (BEI) through DARS. The increasing need for additional qualified interpreters to serve this population poses challenges to DARS to serve Texans who are deaf or hard of hearing.

It generally takes several years to reach the level of fluency in American Sign Language necessary to become a qualified interpreter. Sixty percent of interpreters

certified in Texas by the BEI are certified at the Level I or basic level. It is unknown how many non-certified people are providing interpreter services. The use of non-certified interpreters may have serious consequences for Texans who are deaf or hard of hearing, especially in a medical or courtroom setting. For example, inadequate services from non-certified interpreters have yielded life-altering consequences, such as persons unjustly incarcerated and patients receiving serious medical treatment without appropriate consultation before surgery.

There are 15 Interpreter Training Programs (ITPs) in Texas; 14 are offered by a community college. Graduates from ITPs have obtained basic proficiency in sign language but often require more training and experience to obtain the skills necessary to become a BEI-certified interpreter.

Planned Actions

To increase the capacity to meet the needs of Texans who are deaf or hard of hearing, DARS will develop strategies to increase the number of qualified interpreters through collaboration with community colleges and universities to better prepare graduates of ITPs for certification testing. DARS will:

- Increase outreach efforts with community and faith-based organizations to recruit more people to become signed interpreters;
- Pursue an agreement with the Texas Higher Education Coordinating Board to conduct an analysis of current ITPs and graduates and to identify additional training needs of pre-certified interpreters;
- Establish an ad hoc committee of leaders within the interpreting profession, including ITP representatives, to develop a statewide training plan to address the training needs of non-certified interpreters; and
- Collaborate with community partners, such as community colleges, universities, interpreter referral agencies, independent school districts, and interpreter organizations, to develop and provide additional interpreter training to candidates interested in pursuing certification.

7.3.4 Implementing Changes to the DARS Autism Program to Efficiently and Effectively Serve Children with Autism through Evidence-Based Practices

<u>Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.</u>

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

Discussion

To meet the growing demands for effective treatment services for children with an autism spectrum disorder (ASD), DARS developed the Autism Program as a pilot project in fiscal year (FY) 2008. Through the project, treatment services that use an applied behavior analysis (ABA) approach have been offered to children ages three through eight who have a diagnosis of ASD. The Autism Program currently has six providers serving the greater Houston area, Dallas, Fort Worth, Austin, and San Antonio. Services are provided through contracts with local community agencies and organizations that provide ABA services. ABA services are intensive and have a high cost per child served. Before expanding services into additional areas of Texas, it is important to ensure that the program treatment model is the most effective and efficient intervention for children with autism.

As research on effective treatment of autism continues to become available, and at the direction of state leadership, the Autism Program has worked with the University of Texas at Austin School of Special Education to:

- Research evidence-based treatment modalities;
- Analyze the outcome data for children in the Autism Program; and
- Make recommendations to DARS leadership for changes to the Autism Program that would result in serving more children with autism, continuing to make a measurable improvement in their behavior and development.

In addition to the evidenced-based treatment models that are being identified, there continue to be new innovative interventions for children with autism that, while not having significant evidence of effectiveness in treating autism, show promise of other positive outcomes for children. These innovative interventions need additional research and documentation of effectiveness before being widely offered as treatment in the Autism Program.

Planned Actions

To implement changes to the Autism Program to serve children with autism efficiently and effectively, DARS will:

- Implement changes to offer a comprehensive ABA treatment service and a focused ABA treatment service;
- Expand the Autism Program into El Paso and one additional unserved area of Texas for FY 2015, with an objective for FY 2016 to provide both comprehensive and focused ABA services in all service locations; and
- Pilot innovative and emerging service delivery models and evaluate their efficacy.

Based on the research performed by the University of Texas, information from current Autism Program contractors, and presentations from groups offering other

treatment models, DARS will identify additional ABA models and other treatment modalities which could be implemented in FY 2015 and in future biennia.

7.3.5 Evaluating and Improving Service Delivery across the Texas Independent Living System

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

- Improve coordination and accessibility of veterans' health services and employment opportunities, as appropriate, within the health and human services system.

Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.

- Partner with people with disabilities, including people with behavioral health issues, in overcoming barriers to full participation in the community and the workforce.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.

Evaluating the Independent Living Network to Identify Service Gaps and Redundancies, Develop Strategies to Increase Independent Living Program Efficiencies, and Implement Independent Living Program Improvements. Improving Measurement, Collection, and Reporting of Outcome Data Related to Services Offered by Texas Centers for Independent Living

Discussion

The purpose of the independent living (IL) network in Texas is to support the leadership, empowerment, independence, and productivity of Texans with disabilities and their integration and full inclusion in the mainstream of community life. The IL network includes the Texas State Independent Living Council (SILC), the 27 Centers for Independent Living (CILs) in Texas, other stakeholders in the disability community, and DARS. The purpose of the SILC is to develop and monitor a three-year statewide plan, known as the State Plan for Independent Living (SPIL), which guides the efforts of the Texas IL network. CILs are non-residential organizations that help people with disabilities to live independently in their communities.

The IL network is challenged to provide effective outcome-related information for stakeholders and oversight authorities. Most information made available through federal and state reporting about activities performed by CILs is related to outputs rather than outcomes. Data regarding CIL performance include outputs such as counts of activities performed, services provided, and/or workshops conducted. As such, the quantity of work performed by CILs can be described objectively, but the result of the work performed is subjective. Most outcome-related information is narrative in nature and cannot be quantified or easily reported.

The SPIL broadly defines goals and describes objectives to be achieved by the IL network. Current goals address opportunities to increase the level of collaboration among IL network members and to increase the development and implementation of consistent reporting methods and outcome measures. These actions are necessary to achieve optimal coordination of services to Texans and to effectively demonstrate the impact and results of IL network services in the lives of Texans with disabilities.

Planned Actions

To improve measurement, collection, and reporting of outcome data related to services offered by Texas CILs and to better identify service gaps and redundancies in the IL network, DARS will:

- Launch an agency IL improvement project to:
  - Evaluate and streamline IL case management and purchasing policies and processes;

  - Evaluate and streamline staffing patterns to achieve more efficient and timely delivery of services; and
  - Evaluate DARS IL programs to identify and implement improvements in the service delivery model to ensure effectiveness, efficiency, and optimal coordination with the services provided by CILs;
- Participate in the work of the IL network, facilitated by the SILC and all 27 Texas CILs, to standardize and enhance data collection, measurement, and reporting of outputs, and to develop appropriate measurement of outcomes for IL services; and
- Evaluate CIL funding, contracting, and reporting processes to:
  - Ensure maximum effectiveness of funding,
  - Establish clear expectations regarding achievement of specified outcomes, and
  - Incorporate strategies to improve coordination between DARS IL programs and the services provided by CILs.

Promoting Independent Living Services for Veterans with Disabilities in Coordination with Other Services for Veterans

Discussion

Returning soldiers may face a variety of challenges as they reintegrate into civilian life, and these challenges can be particularly complicated if the veteran has acquired a disability, whether physical, sensory, psychiatric, or cognitive. With an increase in the number of veterans with disabilities, the IL network providers should have in-depth knowledge of the needs of veterans who have disabilities. Many of these veterans may not have employment goals but may desire to live independently in their home and community. Whether by establishing strong referral protocols with local or state agencies which serve veterans, or by serving veterans directly, IL network providers should be knowledgeable about the needs of the growing population of veterans with disabilities who seek information, assistance, or referrals to publicly funded services.

According to the *Veterans in Texas: A Demographic Study*, published by the Texas Workforce Investment Council in December 2012, approximately 27 percent of Texas veterans, or 430,988 people, reported having some type of disability, compared to 14 percent of the 18-year-old and older non-veteran population. Ambulatory difficulty was most frequently reported, followed by difficulties related to hearing, independent living, cognitive function, self-care, and vision. Of those veterans, only a small percentage who could potentially benefit from IL services receives them. While there are numerous programs and initiatives, both public and private, at the state and federal level that serve veterans, few of these have specific services for veterans with disabilities, and fewer still have services for veterans who are blind or visually impaired.

As the veteran population grows, the number of veterans experiencing blindness or vision difficulty related to military service will increase. As the veteran population grows older, the number of veterans experiencing blindness or vision difficulty unrelated to military service will also increase. While these services may be available from the United States Department of Veterans Affairs (VA), most programs have associated waiting lists.

Planned Actions

To promote IL services for veterans with disabilities, in coordination with other services for veterans, DARS will:

- Evaluate policies, procedures, and rules to provide seamless and efficient access to services for veterans who are not eligible to receive services from the VA's blindness program or who may not be able to access those services due to geographic barriers, timeliness of service delivery, or limited availability of services;
- Enhance coordination with other public and private entities serving veterans, including the VA, to ensure a mutual understanding of available services, application procedures, and eligibility requirements;
- Provide additional resources and training to IL workers to increase their ability to provide services to veterans;
- Increase outreach to veterans with disabilities by working with stakeholders involved in veterans issues;
- Explore options to enhance communication with and identification of veterans in need of IL services; and
- Work with the Health and Human Services Commission's (HHSC's) Veterans Initiative to better coordinate services with other agencies within the Health and Human Services System.

Increasing Staff Knowledge and Skills with Effective Independent Living Strategies for Serving Consumers Who Are Blind and Have Additional Disabilities or Are Deafblind

Discussion

To address their independent living needs adequately, maximize their strengths, and mitigate their weaknesses, consumers who are blind and have additional disabilities or are deafblind require assistance with adapting to their environments within the framework of their family and community.

People who are deafblind are challenged in all aspects of their lives. They must find individualized ways to communicate, navigate their surroundings, and identify social, living, and community situations that fit their needs and abilities. Communication and mobility are the two areas most affected by the loss of sight and hearing. DARS

Division for Blind Services (DBS) needs to develop new strategies for effectively serving this population.

Since the incidence of blindness increases with age, DARS expects the need for DBS IL services to increase in the future as the Texas population ages. Additionally, more consumers will have multiple disabling conditions.

Planned Actions

To increase staff knowledge and skills with effective IL strategies for serving consumers who are blind and have additional disabilities or are deafblind, DARS will:

- Research and implement best practices and seek stakeholder feedback on solutions and strategies for improving services by:
  - Developing new ways for stakeholders to provide input;
  - Partnering with the DARS Division for Rehabilitation Services to better serve consumers with autism; and
  - Reviewing and assessing policies, procedures, and rules to identify and develop changes to serve these consumers more effectively;
- Increase coordination and develop partnerships with other state and community organizations that serve people with developmental or intellectual impairments and mental health conditions by partnering with:
  - Organizations that serve people with these disabilities, to develop resources and expand knowledge about best practices;
  - HHSC, to identify best practices and potential community partners and to facilitate service coordination; and
  - The Helen Keller National Center for Deaf-Blind Youths and Adults;
- Build staff capacity and expertise to serve these populations through implementation of best practices by:
  - Developing and implementing training for DBS IL workers to enhance their capacity to serve these populations;
  - Designing training to meet a variety of learning needs, including online and instructor-led formats;
  - Making deafblind specialists available to support the service delivery to consumers who have a vision and hearing loss; and
  - Collaborating with outside training resources through universities and rehabilitation organizations; and
- Address caseload growth to allow DBS to serve additional unserved people and increase the quality and quantity of services provided to the underserved.

Enhancing the Availability of Technology That Is the Key to Consumer Independence

Discussion

Businesses and public entities are increasingly turning to technology to interface with customers. As a result, technology is becoming important to independence in the community for people who are blind or visually impaired. Consumers must be able to learn the necessary skills required for remaining independent after a loss of vision, such as shopping or paying bills; two tasks frequently accomplished using technology. The availability of technology to consumers and the opportunity to learn and gain proficiency in current technology is critical. Consumers using outdated technologies will encounter difficulties as operating systems and software become obsolete or are no longer supported by the manufacturer.

Advances in communications technology have given customers new ways to purchase products and engage in the civil and social lives of their communities. However, these benefits have remained largely unavailable to consumers who are deafblind. Support services for this population, such as training, are often not available. To address the technological communications needs of consumers who are deafblind, DARS developed a partnership with the Perkins School for the Blind and the Helen Keller National Center for Deaf-Blind Youths and Adults to establish iCanConnect through the National Deaf-Blind Equipment Distribution Program. People who are deafblind need additional adaptations to access technology commonly used by people who are blind or visually impaired.

Planned Actions

To enhance the availability of technology that is important to consumer independence, DARS will:

- Ensure there are current technologies available for consumers to use in training situations by:
  - Assessing the need among IL staff working directly with consumers for demonstration and training technology, and
  - Making appropriate technology available to staff for demonstrations and trainings in consumers' homes and other community locations, and
- Make technology available to consumers who are blind or visually impaired for use in community settings that will enable them to become or remain independent in a wide range of settings by:
  - Assessing the feasibility of establishing technology resource and training locations within community organizations that are accessible to IL consumers, as well as to other people who are blind and visually impaired,
  - Partnering with community organizations that provide services to older adults and people with disabilities, and

  - Partnering with community organizations to identify people in need of technology to maintain their independence; and
- Research advances in technology to ensure IL workers are aware of and take advantage of current technology as it and associated peripherals and software change by:
  - Identifying opportunities to obtain current technology information from organizations that develop and access new technology for people who are blind or visually impaired;
  - Participating in technology conferences and demonstrations, communicating with technology developers, and assessing new and updated technology; and
  - Facilitating IL staff access to current information about technology that would contribute to the maintenance or restoration of consumer independence.

7.3.6 Evaluating and Improving Comprehensive Rehabilitation Services Provided to Texans Who Have Traumatic Brain Injuries and/or Spinal Cord Injuries

Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.

- Partner with people with disabilities, including people with behavioral health issues, in overcoming barriers to full participation in the community and the workforce.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Discussion

The Comprehensive Rehabilitation Services (CRS) program helps persons with spinal cord and traumatic brain injuries to receive intensive therapies to increase independence. Depending on the individual's needs, the CRS program provides for one or all of these treatments:

- In-patient Comprehensive Medical Rehabilitation,
- Outpatient Services, and
- Post-Acute Traumatic Brain Injury Services.

In early 2014, DARS completed a one-year improvement project for CRS program operations. The project resulted in a number of key accomplishments and system enhancements, including improved processes for projecting program expenditures and managing the waiting list for program services using a newly-developed predictive model. The project also resulted in implementation of rigorous processes for monitoring cost estimates for program services, as well as encumbrances and expenditures.

Services provided by the CRS program are intensive and have a high cost per consumer served. It is important to ensure that the program treatment model is the most effective and efficient intervention. As research evolves on the most effective treatment, DARS must ensure the existing CRS treatment service array is consistent with that research. Current research will be used to assess program outcomes, the array of services to be offered, the target population, program priorities, service delivery system, and a rate-setting method.

In addition, the program must ensure that protocols are in place to ensure that consumers are receiving the most appropriate service intensity and service array to address their individual treatment needs.

Planned Actions

As part of its ongoing efforts to improve the CRS program, DARS will:

- Contract with a research organization to identify best practices for serving consumers who have traumatic brain and/or spinal cord injuries;
- Partner with stakeholders and service providers to improve CRS outcomes, by soliciting and incorporating feedback from them regarding best practices in serving the target population;
- Partner with the Health and Human Services Commission to develop and establish rates for the program that are accurate and applicable statewide;
- Explore standardized assessments to be used by providers regarding the status of consumers participating in CRS programs;
- Inform hospitals, trauma centers, and other state programs about the CRS program (i.e., services offered to eligible consumers) by meeting face-to-face, telephone conference, and email to ensure that referral sources have accurate and timely information about the CRS program; and
- Provide additional training for CRS staff to increase their knowledge, skills, and capacity to serve consumers with traumatic brain injuries and/or spinal cord injuries.

7.4 Internal Challenges and Opportunities

7.4.1 Continuous Improvement of Business Processes

Quality Assurance Processes

Discussion

A quality assurance and continuous improvement system has become an essential element in continuous improvement efforts in publicly-funded programs across the United States. A quality assurance and continuous improvement system:

- Helps organizations yield the desired results and brings actual performance in-line with standards and best practice; and
- Is most effective when it is centered on measures that are objective, focused and intentional, and is an iterative and ongoing process.

Program evaluation is part of a quality assurance and continuous improvement system and is carried out to assist an organization with making necessary policy and practice decisions to improve consumer services and outcomes. The framework for program evaluation involves engaging stakeholders, deciding what facet of a program to evaluate, gathering credible evidence through personal interviews and quantitative data, justifying the conclusions, using and sharing lessons learned, and looping back with stakeholders. Program evaluation is a systematic tool organizations use to improve program services and demonstrate accountability to the public.

The DARS Division for Rehabilitation Services (DRS) and Division for Blind Services (DBS) have identified an opportunity to jointly develop and implement a rigorous quality assurance and continuous improvement system framework to strengthen compliance, increase efficiency and effectiveness of program operations, and ensure consistency in the quality of consumer outcomes and casework. Implementing a continuous quality assurance and program improvement process will assist DRS and DBS with routinely identifying areas where improvement is needed, as well as recognizing and replicating areas in which improvements and best practices are observed.

DRS and DBS have implemented quality improvement strategies for several programs; however, DARS would benefit from development and implementation of a consistent, rigorous framework, which can be applied to all consumer programs in these divisions.

Planned Actions

DRS and DBS will develop and implement a quality assurance and continuous improvement framework by:

- Expanding the recently implemented Monitoring Oversight and Internal Controls quality assurance system currently utilized in DRS;
- Identifying compliance measures and deciding on priority elements of casework, consumer engagement, and outcomes for improvement, to include:
  - Compliance measures such as regulatory requirements, feedback from monitoring, and performance measures; and
  - Priority elements such as consumer feedback collected from satisfaction surveys and stakeholders;
- Enhancing or modifying current data systems, when needed, to track each element of interest;
- Analyzing relevant data on a routine basis to identify priority areas where intervention is needed, as well as identifying areas where improvement was observed;
- Developing and implementing a plan to intervene when needed; and
- Monitoring the improvement plan to determine if results were achieved, and examining factors where improvement was observed to replicate those factors in other areas.

As part of a quality assurance and continuous improvement framework, DRS and DBS will also undertake an evaluation of consumer programs, which will include data collected from gap analyses, risk assessments, high priority performance issues, and feedback from stakeholders. The evaluation will:

- Engage stakeholders throughout the process,
- Determine program elements to evaluate,
- Gather qualitative and quantitative data,
- Validate conclusions drawn from the data collected, and
- Share and apply lessons learned to other programs or program areas as appropriate.

Contract Management Processes

Discussion

DARS works in partnership with the Health and Human Services (HHS) System agencies to improve, streamline, and standardize contract management across the system. A team of specialists from each of the HHS System agencies has developed a Contract Management Manual with guidelines and practices for successfully managing contracts. DARS facilitates development of policies and

procedures to implement HHS System contracting initiatives, communicating and seeking input from agency stakeholders as appropriate.

To improve contract management and strengthen contracting processes, practices, and accountability, DARS established a consolidated contract management organizational structure. This contract management structure includes resources supporting all DARS program and administrative contracts.

Additionally, Senate Bill (S.B.) 1681 (83-R) codified requirements for all contract managers to be certified by the Texas Comptroller of Public Accounts.

Planned Actions

To improve the DARS contract management process, DARS will:

- Ensure DARS contract managers complete training and obtain certification by September 1, 2015, to comply with S.B. 1681 (83-R);
- Develop contracting processes and procedures to implement and integrate the HHS System contract management manual and other HHS System contracting initiatives; and
- Continue efforts to develop, strengthen, and streamline contract management processes within the new contract management structure.

Consumer Procurement Processes

Discussion

In April 2013, the DARS procurement function consolidated with the Health and Human Services Commission (HHSC) Procurement and Contracting Services (PCS). DARS works in partnership with HHSC PCS to delineate and refine consumer procurement responsibilities to efficiently and effectively align with HHS System procurement processes and requirements.

Planned Actions

DARS will conduct an internal assessment of business requirements in case management system processes to align with HHSC PCS requirements. As appropriate, DARS will change contract management systems and other agency processes based on the internal assessment of business requirements.

7.4.2 Maintaining and Developing the Workforce

Center for Learning Management

Discussion

The Center for Learning Management (CLM) develops, delivers, and supports training in program skills and professional development for DARS employees. CLM is dedicated to maximizing employee competencies, ensuring employee professional growth, and expanding careers through innovative, accessible, customer-focused training.

CLM is authorized by the Commission on Rehabilitation Counselor Certification to approve and issue continuing education units (CEUs) for certified rehabilitation counselors (CRCs) for training programs offered to DARS employees by CLM staff or other trainers approved by CLM.

CLM has been authorized to approve CEUs under domain focus areas that include ethical standards, general vocational rehabilitation (VR) counseling, and professional development specific to professional advancement or VR services.

Planned Actions

In fiscal years 2015 and 2016, CLM will continue working with the DARS Division of Rehabilitation Services and Division of Blind Services to update and refine program-based training for new VR counselors and VR support staff. These projects are guided by the philosophy that learning is a dynamic process, involving a combination of on-the-job training, classroom-based training, online resources, self-study, and access to subject matter experts, for both new and experienced counselors. Redesigned courses will focus on training new counselors and support staff in the core knowledge and skills necessary to perform jobs successfully. Development and implementation of additional training for direct service delivery staff are also planned, in the priority areas of purchasing, specific disabilities, caseload management, and customer service.

Workforce Development and Succession Planning

Discussion

DARS continues to develop the agency workforce through a succession planning model. This model ensures DARS staff will have the necessary competencies to continue to provide excellent services to agency consumers.

Succession planning is a proactive strategy to protect the agency from the loss of key personnel and the resulting impact such losses would have on operations. Effective succession planning provides managers with a strategic basis for making

human resources decisions and allowing managers to anticipate change rather than react to it. Succession planning also allows organizations to project retirement rates and make plans for replacing lost staff competencies and institutional knowledge. The overall benefit of succession planning is its ability to sustain the organization so that it can continue to provide effective services. The DARS model of succession planning provides the framework for the agency to:

- Prepare for contingencies that could prevent DARS from attaining its goals,
- Enable managers to develop a better understanding of areas that need to be strengthened,
- Have a strategic basis for making business decisions,
- Be proactive versus reactive in anticipating staffing needs, and
- Limit the impact of staffing changes on consumer service.

DARS has focused on targeted technical succession planning. Key technical positions have been identified as being at greatest risk, based on the potential of being unable to replace lost knowledge, talent, and skills, resulting in an inability to meet consumer needs. Succession planning incorporates the idea that experienced and knowledgeable staff must document and share their knowledge so the organization may continue effectively carrying out its mission. DARS has identified high-risk positions and is seeking strategies to transfer knowledge among staff where possible.

Planned Actions

Through the DARS Succession Planning Model, DARS will:

- Identify the knowledge, skills, and personal attributes that an incumbent needs to provide critical products and services unique to his or her position; and
- Identify mitigation strategies if staff talent is lost, to ensure service continuity by applying the strategy that is the best fit for each individual employee by choosing from strategies, which may include:
  - Mentoring or shadowing,
  - Knowledge documentation,
  - Job rotation, and
  - Job redesign.

Survey of Employee Engagement

Discussion

The Survey of Employee Engagement (SEE) is offered to all HHS employees every two years by the University of Texas at Austin Institute of Organizational Excellence. This survey is an employee engagement tool that focuses on fully utilizing an organization's human resources to build viable institutions. The SEE assists agency

leadership by providing information about workforce issues that impact the quality of service delivered to consumers. The SEE results provide management insight into not only employees' perceptions of the effectiveness of their organization, but also about employees' satisfaction with their employer.

Planned Actions

DARS executive management will analyze the data and evaluate the information to determine whether any issues identified should be remediated to ensure DARS can effectively fulfill its mission. Results of the 2014 SEE are included in Appendix F.

7.4.3 Addressing Infrastructure Needs

Facilities Maintenance

Discussion

Due to the age of the DARS Criss Cole Rehabilitation Center (CCRC) building, there are ongoing maintenance issues which must be addressed to ensure consumer/staff safety and appropriate space utilization.

Planned Actions

DARS continues to improve work areas within CCRC to increase energy efficiency, eliminate safety hazards, and provide increased security.

Enterprise Content Management Solutions

Discussion

Enterprise content management (ECM) solutions manage the life cycle of information from its initial publication or creation through archival and eventual disposal. ECM includes document management, web content management, information capture, scanning and search, collaboration, records management, digital asset management, and work-flow management. Factors driving DARS to adopt an ECM solution include the need for business continuity, increased efficiency, improved control of information, and reduced overall cost of information management for DARS.

ECM applications streamline access to records through keyword and full-text searches, allowing employees to access the information they need directly from their desktops in seconds rather than searching multiple applications or through paper records.

ECM enhances record control to help agencies comply with federal and state regulations. Security functions include user-level, function-level, and record-specific security options to protect sensitive data. Every action taken within the system can be tracked and is reportable for auditing purposes to comply with a wide variety of regulations.

Planned Actions

DARS will consolidate multiple content repositories into a single repository. Additionally, DARS will define or improve content intake processes and services for efficiency, cost savings, reduced processing time, and upgraded functionality. This includes providing access to a content management tool or solution with capabilities to meet defined requirements such as search, document editing, access, provisioning for different groups, etc.

Work Space Consolidation

Discussion

DARS is housed in approximately 145 leased offices throughout the state. Consolidation of office space wherever possible can save valuable resources that may be re-directed to serve consumers and save taxpayer funds.

Planned Actions

DARS will continue looking for and assessing every opportunity to consolidate space internally and with other Health and Human Services (HHS) System partners to reduce its office footprint and achieve cost savings. This includes:

- Actively participating in the HHS Enterprise Space Reduction Work Group and supporting its efforts to develop an enterprise-wide strategy for reducing office footprints; and
- Assessing the role of and integrating (where appropriate) cost containment strategies, such as telework and mobile work.

ReHabWorks Modifications

Discussion

DARS deployed ReHabWorks as a single web-based consumer case management system to meet the business needs of the Division for Rehabilitation Services and Division of Blind Services. The ReHabWorks deployment project concluded in February 2013; however, DARS will need to continue monitoring and maintaining the system to respond to changing business needs and evolving business processes.

Planned Actions

DARS continues to plan and schedule ReHabWorks enhancement projects based on current business needs as prioritized through DARS Information Technology Governance and the Application Change Control Management Board.

DARS will continue to enhance policies and procedures, and to execute management controls over application changes as important components of overall project management.

Secure Mobile Workforce

Discussion

A secure mobile workforce refers to a group of workers who perform their duties remotely over secure internet connections. Workforce mobility increases staff productivity and consumer satisfaction by:

- Increasing presence in the field;
- Decreasing response time; and
- Allowing real-time documentation using tablets, Wi-Fi access points, MiFi, (a mobile device that enables connectivity), and portable printers and scanners.

A large number of DARS staff travels extensively to meet with consumers in rural areas. Staff frequently works offsite and needs the ability to scan documents, such as driver's licenses, school records, and other items necessary for inclusion in consumer records.

A key component to a mobile workforce is mobile device management (MDM). MDM addresses deploying, securing, monitoring, integrating, and managing mobile devices, such as smartphones, tablets, virtual desktop units, and laptops. The intent of MDM is to optimize the functionality and security of mobile devices within the enterprise, while simultaneously protecting the agency network.

Planned Actions

DARS will review the current network and security infrastructure, with a focus on capacity and security components, to ensure a secure and scalable network. DARS will evaluate the need to procure network equipment and security devices to provide voice and data connections to the mobile workforce. Additionally, DARS will develop a pilot for virtual desktop technologies and services.

DARS will continue to expand the use of mobile devices to service delivery staff. This includes exploring web security gateway services for mobile device management. To support the use of mobility devices, DARS will develop a mobile

device management policy and solutions to ensure the protection of sensitive consumer information.

Security Program Improvements

Discussion

DARS will continue to improve its information security structure by implementing technologies outlined in the security program assessment completed in 2013 and the resulting implementation roadmap. Items remaining on the roadmap to be completed include:

- Proper monitoring and authentication against critical network and security resources, application vulnerability, and security assessments;
- Ability to efficiently control what devices can connect to DARS network resources and security process; and
- Procedural improvements that will enable the efficient detection and remediation of information security issues.

As the need for DARS staff to become more mobile increases and mobile strategies are developed, the agency will need to develop controls around access into DARS networked environments. Controls should be in place to ensure monitoring and privilege levels are appropriate when employees are connecting to critical security and networking resources. DARS currently has no formal assessment of security vulnerabilities for applications. To ensure application code has been evaluated before promotion to production, DARS Information Technology staff will need to deploy and formally document assessment procedures into the software development life cycle (SDLC).

Planned Actions

The DARS information security officer will determine the need to procure and deploy systems and security controls such as network access controls, advanced authentication, and web application vulnerability testing.

Network Access Controls

The information security team will engage with DARS network support to assess and procure a suitable solution to enable secured access for DARS users while eliminating the ability for rogue connections to be made to the DARS network.

Advanced Authentication

The information security officer will engage with DARS network support to develop and deploy advanced authentication mechanisms that will authenticate and set

privilege levels for privileged accounts on DARS critical network and security infrastructure.

Web Application Vulnerability Testing

The information security officer will engage with the DARS application development and quality assurance teams to assess needs surrounding the addition of web application security testing into the SDLC. Once determined, DARS will procure an appropriate solution and document any changes in the SDLC.

7.4.4 Improving Data Quality and Use

Cross Agency Data Alliance

Discussion

DARS collects and has access to a variety of data. Not only can management access data from internally developed consumer case management systems, data is also available through state-maintained financial accounts, contracts, and inquiries and human resources systems. Organizationally, the DARS Program Reporting and Analysis (PRA) unit provides data support through information products and services such as statistical reports, maps of consumer services, analytical reporting, and consultation for regular business operations or special projects.

Accessing quality and timely data from these systems has been the foundation of informed decision-making in DARS. Due to changes that occur in data systems, staff, organizational structures, and business needs, DARS has identified the need for an internal forum to discuss and identify improvement opportunities for accessing and utilizing data. This forum will guide the activities performed by PRA and identify needed changes to data systems within DARS that help the agency to anticipate and adapt to changes.

Planned Actions

PRA will build upon relationships established with DARS program areas and the Information Technology area by creating an agency Data Alliance workgroup to enhance the systematic approach to addressing DARS' data reporting and analysis needs.

The Data Alliance workgroup will bring together internal DARS stakeholders to review data and data analysis needs, to recommend priorities, and to track actions to enhance DARS' capacity to report data and utilize information for planning and decision-making.

As the workgroup and process develop, the Data Alliance will also serve as a unique forum for raising data issues that affect multiple business areas, such as disseminating knowledge of data resources and addressing needs for applied use of data. The workgroup will provide a structure for gathering input, developing recommendations for executive approval, and tracking progress on those actions.

7.5 Agency Goals: Target Populations and Services Descriptions

7.5.1 DARS Goal 1: Children with Disabilities

Early Childhood Intervention Services

Target Population

The DARS Division for Early Childhood Intervention Services (ECI), through contracts with local agencies (ECI local programs), provides early intervention services to children with developmental delays and disabilities from birth to age 36 months to mitigate or eliminate the gap between their current and expected developmental trajectory.

Federal regulations require states to base eligibility criteria on a rigorous definition of developmental delay. They also require states to serve all eligible children. In Texas, eligible children are those who live in Texas, are younger than age three, and have one or more of the following three conditions:

- A developmental delay, documented on a standardized testing tool, of at least 25 percent in one or more of the following developmental areas:
  - Cognitive,
  - Motor,
  - Communication,
  - Social-emotional, and
  - Self-help skills;
- A medically-diagnosed condition with a high probability of leading to a developmental delay. Diagnoses are on an approved list that is reviewed and revised with pediatricians. Examples include cerebral palsy, Down syndrome, failure to thrive, seizure disorder, and spina bifida; and/or
- An auditory or visual impairment, as defined by the Texas Education Agency in 19 Texas Administrative Code Section 89.1040. This determination is made by a team led by certified staff members from the local independent school district.

Younger children are more likely to enter ECI local programs with medically-diagnosed conditions, which often are present at birth. Older children are more likely to enter ECI local programs with developmental delays that are identified when milestones of walking and talking are missed.

Data points to illustrate the target population for fiscal year (FY) 2013 are as follows.

- Number of children who were referred: 68,172
- Number of children who received comprehensive services: 48,193
- Gender: male, 64 percent; female, 36 percent
- Age at enrollment:
  - 25-36 months: 30 percent
  - 13-24 months: 34 percent
  - Birth-12 months: 36 percent

Services Description

DARS ECI provides infants and toddlers with disabilities and their families with early intervention services through a statewide, comprehensive, coordinated, multidisciplinary, and interagency system. ECI services enhance the development of infants and toddlers with disabilities and also enhance the capacity of families to meet their child's needs.

Early intervention is an effective way to help very young children catch up or address specific developmental concerns as soon as possible and before they are eligible for special education services. Early intervention reduces education costs by minimizing the need for special education. ECI services also minimize the likelihood of institutionalization and maximize the potential for independent living.

The following are outcomes that reflect substantial increases in rates of growth and changes in development beyond what would be expected without intervention.

- Action to meet needs (self-care): 77 percent
- Knowledge and skills: 76 percent
- Social relationships: 70 percent

ECI contracts with 51 ECI local programs statewide (through community centers, education service centers, and private nonprofit organizations) to provide early intervention services. ECI local programs work with families and other caregivers to help children overcome delays and make developmental progress. Each local organization has responsibility and authority to implement the Individuals with Disabilities Education Act, Part C, for their designated local service area in Texas.

Under federal law, DARS, as the lead agency to provide ECI services, must have the following in place:

- Policies that:
  - Establish state eligibility,
  - Ensure appropriate evidence-based early intervention services are delivered in natural environments,
  - Ensure qualified personnel deliver services, and
  - Address contracting with early intervention service providers and procedures for securing timely reimbursements of funds;
- A comprehensive child-find system and public awareness program;
- A comprehensive system of personnel development;
- Procedural safeguards to ensure families' rights;
- A system for compiling data; and
- A state interagency coordinating council.

Contract management and oversight are central functions of ECI. ECI establishes policy based on approved rules and then monitors, provides technical assistance, and imposes sanctions to implement the rules. ECI local programs focus on delivering services and complying with the rules and contract requirements.

Children are referred for early intervention services by family physicians, hospitals, family friends, social workers, day care providers, or others familiar with the child and with early intervention services. Families and professionals work together to evaluate the child, develop an Individualized Family Service Plan (IFSP), and ensure that appropriate services based on the unique strengths and needs of the child and family are offered.

Children and their families receive services in their natural environments where children typically learn, live, and play and where children without disabilities participate in daily activities. These environments may include the child's home and places the child goes regularly such as child care or the park. Professionals on the provider team may include licensed or credentialed early intervention specialists, speech and language pathologists, physical and occupational therapists, psychologists, registered nurses, dietitians, social workers, and counselors.

Core Components of ECI are as follows.

- **Individualized Planning Process—**Once eligibility is determined, an interdisciplinary team, which includes the family, develops an IFSP. The services in the IFSP are provided in a location chosen by the family.
- **Family-Centered Services—**Services are based on the needs and concerns of each family and child. ECI professionals and family members incorporate activities into the child's and family's daily activities to promote the child's development.

- **Case Management—**Service coordinators help families access and receive the services, resources, and supports they need to support their child's development. Supports include helping the child and family transition to special education services as appropriate for children exiting ECI at age three. ECI programs provide comprehensive case management for all members of the child's family as their needs relate to the child's growth and development.
- **Services in Familiar Settings—**Though most ECI services are provided at home, they can be provided in other places familiar to the child, such as a childcare center or park.
- **Professional Providers—**The team that evaluates the child and plans services includes licensed or credentialed early intervention specialists, speech and language pathologists, physical and occupational therapists, psychologists, registered nurses, dietitians, social workers, and counselors.
- **Transition Services—**ECI services end when the child turns three. Well before that time, the ECI team, including the family, decides on next steps. Children may transition to public school, preschool, Head Start, childcare centers, or other community activities and programs, or they may stay home with their family. For those children who need further intervention services, the goal is a smooth transition with no service gaps.

Additionally, ECI provides specialized training, respite care, and follow-along services. Follow-along services track the developmental progress of children who are not eligible for comprehensive services but may be at risk for developmental delay.

The ECI also provides a credential for early intervention specialists who work for an ECI program. The credential is based on a curriculum and requirements approved by ECI, and it is not transferrable to other service programs or providers.

Services for Blind Children

Target Population

The Blind Children's Vocational Discovery and Development Program (BCVDDP) serves children from birth to age 22 who are blind or visually impaired and reside in Texas.

Data points to illustrate the target population for FY 2013 are as follows.

- Consumers served: 4,224
- Gender: male, 55 percent; female, 45 percent
- Percent of consumers younger than age nine: 87 percent

Services Description

BCVDDP, also known informally as the Blind Children's Program (BCP), helps children who are blind or severely visually impaired to learn the skills required for personal independence, potential employment, and other life pursuits. Habilitative services provided by BCP enhance a child's ability to develop skills comparable to his or her peers and help children achieve financial self-sufficiency as adults. DARS blind children's specialists serve the dual functions of case manager and direct service provider.

DARS blind children's specialists complete comprehensive assessments for each child to gather information necessary to plan core services. Family needs are documented during the comprehensive assessment and throughout service delivery. The plan is always developed through mutual participation and acceptance by the specialist, child, and family.

Case management services help children who are blind or visually impaired gain access to medical, social, educational, vocational, and other appropriate services that help them reach or maintain optimal levels of functioning in the community. An important aspect of case management is the monitoring of services to ensure assessed needs are appropriately addressed. Case management services help families understand and access available services by:

- Identifying other community resources;
- Identifying comparable benefits and resources, reviewing the family and consumer's eligibility for those benefits and resources, and helping the family and consumer contact appropriate resources;
- Providing appropriate application forms;
- Preparing the family or consumer for referral;
- Arranging and/or attending appointments, if necessary; and
- Following up with service partners.

DARS blind children's specialists provide specialized services that include:

- Targeted case management,
- Counseling and guidance for children and their parents,
- Information and referral,
- Training and educational support,
- Skill development,
- Independent living training, and
- Developmental equipment.

These services foster vocational discovery and development while promoting the child's self-sufficiency, thereby decreasing the need for services later and giving the children a solid foundation when they enter the world of work.

Autism Program

Target Population

The Autism Program serves children ages three through eight who are residents of Texas and have an autism spectrum disorder diagnosed by a physician or psychologist with training and background related to the diagnosis and treatment of neurodevelopmental disorders. The program benefits families of children who receive services, schools, and the community at large. Children with autism who experience significant improvements in cognitive, language, social, and adaptive skills can participate in typical classroom and community settings with minimal or no supports. This enables families to more fully participate in their communities and minimizes long-term costs for families, schools, and other services.

Data points to illustrate the target population for FY 2013 are as follows.

- Consumers served: 199
- Gender: male, 75 percent; female, 25 percent
- Consumer age at entry to services: 3–4 years, 75 percent; 5–8 years, 25 percent

The Centers for Disease Control and Prevention (CDC) reported that in 2006, approximately 1 in 110 children in the U.S. had a diagnosis of autism spectrum disorder (ASD). In 2012 the CDC reported an increase in the estimate to 1 in 88 children with ASD. In March 2014, CDC released a new estimate of 1 in 68 children, which is about a 30 percent increase over the previous estimate of 1 in 88. Based on these new numbers, it is estimated that there are more than 77,000 children ages 3 through 15 with ASD in Texas in 2014. That number is projected to increase, growing to approximately 78,890 in 2016.

Services Description

The Autism Program provides applied behavior analysis (ABA) services through contracts with local community agencies and organizations in Austin, Dallas, Fort Worth, Houston, Rosenberg, and San Antonio.

ABA is a therapy that uses behavioral principles to evaluate and teach socially relevant behavior and new skills and to increase desirable behaviors through positive reinforcement. It is the most recommended, evidence-based treatment for autism spectrum disorders. Research indicates that comprehensive ABA services have the most effect on a child's long-term development when it is provided before the age of four years for a duration of 14 to 30 hours a week for two or more years in multiple settings (home, clinic, and community settings). ABA services are customized to the child's individual needs and include an assessment, psychological testing, and a treatment plan. The team that develops the plan assesses progress and adjusts it to address the child's needs and strengths.

Most ABA therapy sessions are delivered by a behavioral analyst to the child through a one-on-one treatment modality. Group sessions may be used when appropriate. Parent involvement and training contribute to the achievement of treatment goals. Services may take place in the home, clinic, and familiar settings in the community. DARS contractors vary in their delivery of ABA services; although all offer comprehensive ABA services, intensity varies from 10 to 35 hours per week. While most Autism Program contractors offer services in a clinic setting, one uses a home-based delivery model. Comprehensive services address all developmental domains. The goal of comprehensive services is to improve a child's overall developmental trajectory which results in little or no additional supports in school.

A second approach using ABA for children with autism, referred to as focused treatment, addresses one or more specific challenging behaviors or developmental needs rather than the full range of developmental domains. Several DARS contractors use this approach, as it has been shown to be effective in reducing challenging behaviors and improving school, family, and community functioning. This approach is less intensive both in hours per week and duration of services than comprehensive treatment. It is less costly than comprehensive treatment; however, while the child may require fewer future public supports, focused treatment is not expected to change the child's developmental trajectory.

7.5.2 DARS Goal 2: Persons with Disabilities

Vocational Rehabilitation Services

Overview

DARS provides vocational rehabilitation (VR) services through the VR-General and VR-Blind programs. Both programs help people with disabilities prepare for, find, and keep jobs. DARS maintains partnerships with businesses to help workers with disabilities, including physical, mental, and sensory disabilities, keep their jobs and cultivate new employment opportunities for VR consumers.

VR services are provided to individuals with disabilities who meet federally established eligibility criteria. Eligibility for VR services is determined by a qualified vocational rehabilitation counselor. The eligibility criteria for both VR-General and VR-Blind services include:

- Physical, sensory, or mental impairment;
- Determination that the impairment constitutes or results in a substantial impediment to employment;
- Determination that the individual requires VR services to prepare for, secure, retain, or regain employment; and
- Presumption that the individual can benefit in terms of an employment outcome from VR services.

Individuals who receive Social Security Disability Insurance and Supplemental Security Income disability benefits are presumed eligible for VR services.

The DARS VR-General and VR-Blind programs provide services for eligible individuals that are consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. The programs offer a variety of skills training, accommodations, and adaptations that are tailored to each consumer's skills, abilities, and interests. The programs are centered on the VR counselor's and the consumer's agreement on the provision of services, with the ultimate goal of helping consumers function as independently as possible in an integrated employment setting.

As part of the VR programs, counselors provide transition planning services for 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/or special education, to provide them information about the availability of VR services. Transition services focus on:

- Reinforcing transition services and strategies,
- Improving partnerships with schools and business, and
- Maximizing the schools' utilization of VR counselors.

Vocational Rehabilitation—General

Target Population

The VR-General program assists Texans who meet the eligibility criteria described above, other than those who are blind or have a significant visual impairment.

Data points to illustrate the target population for fiscal year (FY) 2013 are as follows.

- Consumers served: 79,578
- Gender: male, 55 percent; female, 45 percent
- Average age at application: 36 years
- Veterans: 3,032

Services Description

The VR-General program is administered by the DARS Division for Rehabilitation Services (DRS). The VR-General program helps eligible Texans with disabilities overcome vocational limitations and enables them to prepare for, find, and keep jobs. Together, a consumer and a counselor determine an employment goal that is consistent with the consumer's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. Successful case closures in FY 2013 totaled 12,102.

Work-related services are based on individual needs and may include a variety of services such as:

- Medical, psychological, and vocational evaluation to determine the nature and degree of the disability and the consumer's job capabilities;
- Counseling and guidance to help the consumer and the family plan vocational goals and adjust to the world of work;
- Training to learn job skills in trade school, college, university, on the job, or at home;
- Hearing examinations, hearing aids, other communication equipment, and
- hearing rehabilitation;
- Interpreter services for the deaf and hard of hearing;
- Rehabilitative medical treatment and/or therapy to lessen or remove the disability;
- Assistive devices such as artificial limbs, braces, and wheelchairs to stabilize or improve functioning on the job or at home;
- Rehabilitation technology devices and services to improve job functioning;
- Training in appropriate work behaviors and other skills to meet employer expectations;
- Job placement assistance to find jobs compatible with the consumer’s physical and mental abilities;
- Supported employment services; and
- Follow-up after job placement to ensure job success.

Vocational Rehabilitation—Blind

Target Population

The VR-Blind program assists Texans who meet the eligibility criteria described above and are blind or have a significant visual impairment.

Data points to illustrate the target population for FY 2013 are as follows.

- Consumers served: 10,066
- Gender: male, 53 percent; female, 47 percent
- Average age at application: 37 years
- Veterans: 232

Services Description

The VR-Blind program is administered by the DARS Division for Blind Services (DBS). The VR-Blind program helps the VR-Blind program helps consumers to identify and use available community options and to instill in them the confidence to move ahead independently with employment and life. The VR counselors work with

a variety of sources to ensure that individuals gain the independent living (IL) skills, experience, training, and education needed to reach their desired employment outcome. Successful case closures in FY 2013 totaled 1,341.

Services include a significant amount of training specific to visual impairments and blindness. Examples of specialized services include:

- Guidance and counseling,
- Employment assistance services,
- Assistive technology and equipment,
- Orientation and mobility training,
- Personal and home-care training,
- Job retention services,
- Supported employment services,
- Vocational training,
- Communication/braille skills, and
- Technical assistance with existing and potential employers.

A particularly important core skill for consumers who are blind is orientation and mobility, which allows them to travel independently in any environment they are likely to encounter. Orientation refers to the process of applying the consumer's available senses to establish his or her position in relationship to the environment. Mobility is the act of moving in the environment with use of an established tool, for example, a white cane, service animal, or an electronic navigation device.

Advances in technology have opened many doors in the world of work for people who are blind or visually impaired. As part of its overall consumer training program, DARS maintains an Assistive Technology Unit. This unit evaluates consumer needs and provides the consumer and the VR counselor with recommendations regarding the best equipment to meet the consumer's employment and training needs.

Transition services provide age-appropriate VR services to eligible youths ages ten and older to support them in making informed choices about their future. Transition services prepare these youth for:

- Secondary education;
- Vocational training;
- Integrated employment, including continuing education;
- Independent living; and
- Community participation.

Business Enterprises of Texas

Target Population

Consumers in the DBS VR-Blind program who are interested in the Business Enterprises of Texas (BET) program are referred by their counselor and must:

- Be blind;
- Be at least 18 years old, a resident of Texas, and a United States (U.S.) citizen; and
- Successfully complete all DBS and BET assessment and training requirements to become a licensed BET manager.

Data points to illustrate the target population for FY 2013 are as follows.

- BET Managers: 114
- Gender: male, 84 percent; female, 16 percent
- Average age at application: 48 years

Services Description

The BET program is a federally sponsored, state-administered program that provides training and employment opportunities for Texans who are legally blind to manage food service and vending businesses on state, federal, and private properties throughout Texas. BET recruits, trains, licenses, and places consumers who are blind as operators of these businesses.

BET provides competitive employment outcomes for consumers who have received VR-Blind services. Managers in the program operate as sole proprietors and rely on profits produced by their businesses for personal income. They also pay their employees and buy re-sale products. While BET does not provide VR services, placement as a BET manager is the successful result of those services.

Independent Living Services

Overview

DARS administers independent living services (ILS) through the ILS-General, IL-Blind, and Centers for Independent Living (CIL) programs. ILS consumers are people who have significant disabilities resulting in a substantial impediment to their ability to function independently in their family and community. These individuals face barriers that severely limit their choices for quality of life. Misunderstandings about disability can also limit people with disabilities from living independently.

The number of consumers receiving independent living services has steadily increased due to population growth and people with disabilities living longer.

Independent Living Services—General

Target Population

ILS-General serves people who have significant disabilities, other than blindness or significant visual impairments, resulting in a substantial impediment to their ability to function independently in their family and community.

Data points to illustrate the target population for FY 2013 are as follows.

- Consumers served: 1,977
- Gender: male, 47 percent; female, 53 percent
- Average age at application: 61 years
- Veterans: 80

Services Description

ILS-General promotes independence at home and in the community and enhances the quality of life for people with significant disabilities. Services focus on:

- Personal adjustment to living with a disability,
- Mobility,
- Communications,
- Social skills, and
- Self-direction.

DARS IL counselors work with eligible consumers to develop goals to overcome specific barriers and formulate strategies to achieve those goals. IL counselors work with each consumer to develop an individualized plan that is designed to help the consumer achieve the greatest level of independence possible. Successful case closures in FY 2013 totaled 904.

ILS-General services may include:

- Counseling and guidance;
- The purchase of telecommunications, sensory, and other assistive technology aids for people who are deaf or hard of hearing;
- Wheelchairs and braces;
- Home and vehicle modifications; and
- Other devices or services needed to achieve meaningful independent living goals.

Services are time-limited and based on individual needs and goals. Most requests for ILS involve purchases of assistive technologies and devices. Sufficient ILS funds are not always available to meet immediate consumer demand. A list of consumers

who are waiting to receive non-diagnostic purchased services was developed. This list is referred to as the ILS waiting list. The ILS waiting list is used to:

- Identify who is to be served next when funds become available,
- Track the timeliness of service provisions,
- Track the number of consumers who are waiting, and
- Identify the additional funds needed to meet consumer demand.

Independent Living—Blind

Target Population

Individuals eligible for IL-Blind services must have a visual disability that is a substantial impediment to living independently and that can be improved by the delivery of IL services, increasing their ability to function, to continue functioning, or to move toward functioning independently.

Data points to illustrate the target population for FY 2013 are as follows.

- Consumers served: 3,314
- Gender: male 35, percent; female, 65 percent
- Average age at application: 67 years

Services Description

The IL-Blind program is designed to help Texans who are blind and visually impaired acquire the skills and knowledge they need to remain in their homes, as well as the self-confidence that comes from believing in their own ability to exercise independent choice and to live their life the way they choose within their community. Successful case closures in FY 2013 totaled 1,436.

Program services focus extensively on understanding and experiencing the possibilities of living without fear and/or dependence on others. The primary approach is based on enabling consumers to handle their own daily living activities rather than relying on someone to perform tasks for them, and services are designed to reduce or decrease the need for long-term care. Examples include the following:

- Learning to travel using a cane,
- Shopping and preparing meals,
- Identifying medications,
- Using braille to record and read information,
- Managing financial records, and
- Participating in recreation and other community events.

DBS IL-Blind workers serve a dual function. They are both case managers and direct service providers. As service providers, they assess the consumer's situation

in relationship to key self-help and daily living areas and address training strategies to achieve the consumer's goals. They provide in-home and/or group teaching services that help consumers acquire the skills they need to become independent in their home and actively involved outside the home.

Centers for Independent Living

Target Population

Any individual with a significant disability, as defined by the federal Rehabilitation Act, is eligible for IL services under the CIL program. Eligible individuals may seek information about IL services and request a referral to other services and programs.

A plan or waived plan is created when a person seeks services beyond information and referral. The CIL creates a Consumer Service Record, which is a complete record of services the CIL provides the consumer. This record includes:

- Documentation of eligibility determination;
- Intake information; and
- A signed Independent Living Plan that documents:
  - Specific goals established with the consumer,
  - Services requested,
  - Services provided, and
  - Goals achieved.

If the consumer chooses to sign a waiver form, waiving his or her right to participate in plan development, CIL staff must develop the plan of services the consumer will receive. Services entered on the IL plan or waived plan must clearly support achievement of consumer goals or objectives and be time-limited.

Data points to illustrate the target population for FY 2013 are as follows.

- Consumers served by DARS funded CILs under a plan or waiver: 5,578
- Additional number served (without a plan or waiver): 181,547

Services Description

CILs are community-based, cross-disability, nonresidential, private, nonprofit agencies that provide an array of IL services. They may receive funds from a variety of sources, including DARS and the Department of Aging and Disability Services (DADS). The DARS CIL program contracts with 15 of the 27 CILs in Texas. All CILs provide the following four core services mandated by the federal Rehabilitation Act:

- Information and referral,
- IL skills training,

- Peer counseling, and
- Advocacy.

The majority of the staff who operate CILs have disabilities and/or have been CIL consumers.

CILs help people with disabilities achieve and/or maintain their optimal level of self-reliance and independence. The IL philosophy emphasizes that people with disabilities are the best experts on their own needs, have crucial and valuable perspectives to contribute to society, and deserve equal opportunities to decide how to live, work, and take part in their communities. CILs advance this philosophy and the rights of people with disabilities through consumer-driven advocacy. They further the mission of the independent living system to promote the leadership, empowerment, independence, and productivity of Texans with disabilities and their integration and full inclusion into the mainstream of community life.

Using funds provided by DADS, the majority of Texas CILs help people who are leaving nursing facilities for an environment of their own choice by providing relocation assistance, equipment loans, and assistance with selecting assistive technology to meet their needs. CILs also may contract with other state or federal agencies to provide services, including:

- Counseling,
- Assistance to secure housing or shelter,
- Access to consumer information programs,
- Individual and group social and recreational activities, and
- Community awareness programs.

Other Services to Persons with Disabilities

Comprehensive Rehabilitation Services

Target Population

The Comprehensive Rehabilitation Services (CRS) program serves people who have acquired traumatic brain injuries and traumatic spinal cord injuries. To receive services, the consumer must:

- Have a traumatic brain injury, a traumatic spinal cord injury, or both, which have significantly affected the consumer's ability to perform daily activities;
- Be at least 15 years old;
- Be a U.S. citizen or immigrant alien;
- Have lived in Texas for at least six months or have a primary caregiver who has lived in Texas for at least six months;

- Be medically stable enough to participate in rehabilitation activities; and
- Agree to participate in the services offered by the DARS CRS program.

Data points to illustrate the target population for FY 2013 are as follows.

- Consumers served: 908
- Gender: male, 77 percent; female, 23 percent
- Average age at application: 38 years
- Veterans: 59

Services Description

The CRS program was created in 1991 for people who acquired traumatic brain injuries and traumatic spinal cord injuries, with a goal to increase their ability to function independently within their homes and communities. Program services include impatient comprehensive medical rehabilitation services, post-acute brain injury rehabilitation services, and outpatient therapies. Successful case closures in FY 2013 totaled 471.

Inpatient comprehensive medical rehabilitation services are medical services provided in a hospital. These services are available to consumers when no more than one year has lapsed between the date of injury and the date of initial contact. Services are indicated on an Individualized Written Rehabilitation Plan (IWRP) and may last up to 30 days. An extension may extend services to 90 days without amending the IWRP when recommended by the inpatient interdisciplinary team. The inpatient services are provided by several contracted providers across Texas.

Post-acute brain injury (PABI) rehabilitation services use an interdisciplinary team approach to deliver services aimed at improving cognitive deficits. Services are available to consumers any time after acquiring a traumatic brain injury. Services are indicated on an IWRP and may last up to three months. An extension may extend services on a month-by-month basis, up to six months, without amending the IWRP when recommended by the PABI interdisciplinary team. The goal of services is to increase the consumer's ability to function as independently as possible. PABI services are provided by 21 contracted providers across Texas.

Outpatient therapies include physical, occupational, cognitive, and speech therapy. Depending on the impact of the traumatic injury, combinations of therapies may be most effective to enhance the ability to function in the home and community. Outpatient therapies must be prescribed by a physician. Outpatient therapies are available to consumers when no more than two years have lapsed between the date of injury and the date of initial contact. Services are limited to a maximum of 120 hours. Outpatient therapies are provided by vendors within Texas.

Approximately 60 vocational rehabilitation counselors across the state carry partial CRS caseloads and perform the following functions:

- Determining eligibility,
- Determining medical stability for start of services,
- Developing and monitoring a plan for services,
- Providing counseling and guidance,
- Participating as an active member of the interdisciplinary treatment team,
- Ensuring the consumer has informed choice on selection of provider, and
- Assessing whether goals are met.

Sufficient CRS funds are not always available to meet immediate consumer demand. A list of consumers who are waiting to receive services was developed. A consumer is considered to be waiting for services when an IWRP has been developed and is documented as signed in the consumer case management system. Consumers designated as waiting for services are served in the order in which their original CRS IWRP was written and signed.

CRS success is measured by where the consumer resides after completing CRS services.

Blindness Education, Screening, and Treatment

Target Population

To be eligible for Blindness Education, Screening and Treatment (BEST) screening services, the individual must be an adult resident of Texas who has:

- Been referred to the program by their physician or optometrist;
- Had a physician or optometrist confirm that the individual does not have health insurance or other available resources with which to pay for urgently needed eye-medical treatment to prevent blindness; and
- Been certified by a physician or optometrist as having one of the three qualifying conditions (diabetic retinopathy, detached retina, or glaucoma) or any other eye disease determined to necessitate urgent medical treatment by both the applicant's eye doctor and the DBS ophthalmologic consultant or designee.

Data points to illustrate the target population for FY 2013 are as follows.

- Consumers served: 4,387
- Consumers receiving vision screening: 4,287
- Consumers receiving treatment: 100

Services Description

The objective of the BEST program is to help eligible Texans prevent blindness. The program's two major functions are to provide:

- Adult vision screening services and education to promote proper eye health, and
- Payment for urgently needed eye-medical treatment for adults who do not have health insurance or other resources.

BEST services are designed to reduce the number of Texans who lose their sight. The program encourages Texans to maintain healthy eyes and seek professional care if they are at risk for potentially serious eye conditions. By assisting with medical treatment to prevent blindness, BEST helps Texans retain employment and support their families. The program saves federal and state funds that would otherwise be needed for rehabilitation and social services if blindness occurred.

Screening and treatment services are available statewide. Screening services are available upon request and are provided through a contractor. Treatment services are determined and provided by an appropriately licensed physician. Treatment services do not require a BEST screen.

The program is currently limited to funding derived from the voluntary $1 donation Texans can chose to make when they renew their driver's licenses or identification cards at the Department of Public Safety.

Office for Deaf and Hard of Hearing Services

Target Population

The DARS Office for Deaf and Hard of Hearing Services (DHHS) serves Texans who are deaf or severely hard of hearing.

Data points to illustrate the target population for FY 2013 are as follows.

- Consumers who received communication access services: 46,326
- Consumer who were issued equipment/service vouchers issued: 23,684
- Interpreters who were issued certificates: 1,731
- Consumers who were educated and interpreters who were trained: 1,338

Services Description

Deafness Resource Specialists and Hearing Loss Resource Specialists

DHHS promotes a system of services for individuals who are deaf or hard of hearing and evaluates and certifies interpreters. These deafness resource specialist and hearing loss resource specialist contractors are community-based organizations that provide communication access and other services designed to remove barriers between individuals needing services and the service providers in their communities.

Some DHHS consumers are people who have suddenly lost their hearing as adults resulting in immediate communication challenges.

DHHS resource specialist contractors help individuals to live independently, participate fully in society, maximize their individual potential, and reduce their isolation through:

- Advocacy;
- Outreach and education;
- Youth training;
- Interpreter services;
- Adjustment to and hearing technology services for persons experiencing hearing loss;
- Communication Access Real-time Translation services;
- Interpreter training, including Hispanic trilingual training and certified deaf interpreter training;
- Service provider training about individuals who are deaf or hard of hearing;
- Information and referral services;
- Vocational education and independent living services for individuals who are low-functioning deaf or hard of hearing; and
- Services to older persons to bridge communication barriers and reduce isolation.

Board of Evaluation Interpreters

DHHS also serves the deaf population through the interpreter certification program, which tests, rates, and certifies interpreters for the deaf. Interpreters facilitate communication that directly benefits persons who are deaf or hard hearing in their daily life and in special circumstances, for example, court proceedings. DARS certifies interpreters at varying skill levels, including court interpreters and trilingual interpreters. DARS maintains lists of certified interpreters for courts, schools, service providers, and other interested entities. DHHS has identified a significant interest in potential test candidates, evidenced by the number of pre-certified individuals registering for specialized trainings focusing on test preparation. DARS anticipates that increased attention to the need for qualified interpreters will prompt more candidates to apply.

Specialized Telecommunications Assistance Program

DHHS also administers the Specialized Telecommunication Assistance Program (STAP). This voucher program is funded by the Texas Universal Service Fund, a fee assessed for certain telecommunication services, and provides telecommunication access equipment for persons who are deaf or hard of hearing, who are speech impaired, or who have any other disability that interferes with telephone access. DARS is responsible for determining voucher categories and

values for the purchase of specific devices or services. Vouchers issued include amplified telephones, two-way pagers, big-button telephones, and voice dialers.

DARS contracts with local service providers across the state for outreach activities that help individuals complete the STAP application and determine the equipment most appropriate for needs relating to accessing the telephone.

7.5.3 DARS Goal 3: Disability Determination

Disability Determination Services

Target Population

The target population for Disability Determination Services (DDS) is people who are significantly disabled and unable to work. Social Security Disability Insurance (SSDI) is a cash payment and health care benefit available to those who have a work history and meet the federal definition of disability. People earn coverage for themselves and family members by paying the federal social security tax. The program covers workers prior to full retirement age who are disabled, disabled widows and widowers, or disabled adult children of workers. Claimants must wait five months from the onset of their disability before receiving their first cash payment and 24 months after the first cash payment before receiving Medicare benefits.

Supplemental Security Income (SSI) is a cash payment and health care benefit available to persons who meet the federal definition of disability and who qualify on the basis of income and resources. A person who has minimal resources or income may qualify for this program. SSI covers individuals of any age. There is no waiting period for benefits to start; Medicaid coverage for medical care begins with the first cash payment.

Services Description

DDS makes the disability determinations on behalf of the Social Security Administration (SSA) for the federal SSDI and SSI programs. Both of these programs are governed by the SSA. These programs pay cash benefits and/or provide medical coverage to people who are unable to work because they have disabling physical or mental impairments. These benefits are designed to replace part of lost income or help pay medical bills if a person becomes disabled. DDS makes the medical disability determinations for SSA, but only SSA can determine who is eligible to receive benefits. The DDS receives the claim from a local SSA field office and returns the claim back to that field office when a medical determination has been made for SSA to make a final determination of benefits. DDS's role is to gather medical and other evidence to make a medical determination, which SSA considers a preliminary determination. SSA then makes

the final decision about SS benefits only after the DDS has reviewed the medical evidence and made a medical determination on the SS claim.

An adult, or the parent or guardian on behalf of a child, applies for SSA disability benefits through a local SSA field office in person, online, by mail, or by telephone interview. The SSA field office first verifies that the submitted application meets non-medical SSA eligibility requirements. SSA immediately denies applications that fail to meet non-medical eligibility requirements. The SSA field office then sends eligible disability claims to DDS for medical evaluation and adjudication. SSA transmits eligible claims to DDS using an electronic case processing system, and DDS assigns received claims to disability specialists.

DDS seeks to obtain evidence from the claimant's own medical sources or through a consultative examination in order to obtain evidence to make a medical determination of disability. DDS considers medical and non-medical evidence when making a disability determination, as required by SSA disability regulations. A two-person adjudicative team consisting of a medical or psychological consultant paid by SSA and a DDS disability specialist makes the determination.

The SSA maintains all claimant SS data related to earning records and other personal identifiable information. The DDSs role in the SS disability process is to medically evaluate and adjudicate the claim based on medical evidence as established in SSA policy. Once the DDS has completed the medical evaluation and adjudication of the claim, DDS returns the claim to the SSA field office for appropriate action and communication with the claimant. SSA makes the final decision of allowance or denial on all Social Security disability claims.

Data points to illustrate workload and accuracy for fiscal year 2013 are as follows.

- Social security claims assigned and cleared DDS: 336,908 claims
- Initial accuracy of claims cleared: 96.2 percent (SAA national accuracy is 96 percent.)
- Initial allowance rate: 33.8 percent (SSA national allowance rate: 33.1 percent)
- Initial processing time: 69.8 days (SSA national processing time: 85.9 days)

Chapter 8

Department of Family and Protective Services Strategic Plan 2015–2019

8.1 Overview

The Texas Department of Family and Protective Services (DFPS) is charged with "protecting the unprotected." Twenty-four hours per day, 365 days per year, approximately 10,672 DFPS employees strive to protect children, people who have disabilities, and people who are ages 65 and older from abuse, neglect, and exploitation. DFPS also works to ensure child safety and well-being by its licensing and regulation of day-care and residential operations.

DFPS has several areas to facilitate meeting these important goals.

- **Child Protective Services (CPS)—**CPS' core function is to protect children from abuse and neglect, and work with families to prevent abuse and possible future neglect.
- **Adult Protective Services (APS)—**APS is charged with protecting people ages 65 and older and people who have a disability.
- **Child Care Licensing (CCL)—**CCL is responsible for licensing and regulating Texas' day care operations, 24-hour-per-day residential child-care facilities, and child-placing agencies.
- **Statewide Intake Division (SWI)—**Twenty-four hours per day, 7 days per week, SWI operates as the centralized point of intake for reports of abuse, neglect, or exploitation of:
  - Children;
  - People who are ages 65 and older and people with disabilities, including clients served by the Department of State Health Services (DSHS) or the Department of Aging and Disability Services (DADS); and
  - Children in licensed child-care facilities or treatment centers.

- **Prevention and Early Intervention (PEI)—**PEI is a division of CPS that focuses on preventing abuse, neglect, and delinquency before it occurs. PEI manages and contracts with community-based programs to provide prevention services statewide. Some services are available statewide, and others are available only in some areas.

The remainder of this chapter is arranged as follows:

- Mission,
- External Challenges and Opportunities,
- Internal Challenges and Opportunities, and
- Agency Goals: Target Populations and Services Descriptions.

8.2 Mission

The mission of DFPS is to protect children and people who are elderly or who have disabilities from abuse, neglect, and exploitation by involving clients, families, and communities.

8.3 External Challenges and Opportunities

As introduced in Section 8.1, DFPS serves Texans of all ages in multiple ways, helping to implement all of the Health and Human Services (HHS) System Strategic Priorities.

- Improve and protect the health and well-being of Texans.
- Create opportunities that lead to increased self-sufficiency and independence.
- Protect vulnerable Texans from abuse, neglect, and exploitation.
- Encourage partnerships and community involvement.
- Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.
- Ensure the integrity of health and human services providers.

DFPS is the primary agency responsible for protecting and serving children, people ages 65 and older, and people with disabilities in Texas communities. As the population continues to increase, DFPS is investigating an increasing number of allegations of abuse, neglect, and exploitation.

DFPS, by protecting the unprotected and providing services to vulnerable populations, provides pivotal support to the HHS Strategic Priorities. DFPS, as with all the HHS System agencies, faces diverse and critical challenges. The following sections detail some of DFPS' current challenges and opportunities and the actions DFPS is taking or planning to take to meet those challenges.

8.3.1 Improving Child Protective Services Capacity

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

- Improve access to effective services across systems for behavioral health, including prevention, treatment, and recovery services, and integrate physical and behavioral health services.
- Ensure all programs and initiatives recognize and address health disparities and disproportionality to improve outcomes.

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

- Improve detection of potential risk of harm to vulnerable children and adults in the residential settings regulated by, operated by, or provided via contract with the state and ensure that appropriate services are offered and provided when abuse, neglect, or exploitation is suspected or occurs.
- Work with law enforcement to support prosecutions of people suspected of criminal abuse, neglect, or exploitation.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.
- Work closely with faith- and community-based organizations to assist people in applying for nutrition, medical, monetary, and other assistance.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.

Discussion

When a child is at risk at home, Child Protective Services (CPS) takes all reasonable measures to ensure the safety of the child, while supporting the integrity of the family and its ability to care for the child. Depending on a child's circumstances, there are several stages of services that CPS can provide. These services help address a wide variety of needs and include:

- Conducting civil investigations of reported child abuse and neglect;
- Protecting children from abuse and neglect;
- Promoting the safety, integrity, and stability of families;
- Finding safe and permanent placements for children who cannot safely remain with their own families; and
- Finding safe and committed caregivers willing to take legal custody of children who cannot safely remain with their own families.

During the investigation stage, CPS caseworkers may refer families for services in the community. If there is concern about the continued safety of a child, the caseworker may refer the family for Family-Based Safety Services (FBSS). FBSS includes family counseling, crisis intervention, parenting classes, substance abuse treatment, domestic violence intervention, and day care. These services are provided while the child remains in the home and are helpful in making sure children are safe.

When conditions make it unsafe for children to remain in their own home, removing children from their family may not be the only solution if the family is able to make alternate, safe living arrangements for their children. Sometimes extended family or other adults with close family connections exist who are willing and able to provide care in a safe environment. This type of alternate living arrangement reduces the trauma experienced by the children.

Even as CPS has been serving more children in this family-focused context, there has been an increase in the number of children who must for their safety be removed from their homes, and DFPS assumes legal custody of the children. These children may be placed temporarily with relatives, kinship, a foster family, an emergency shelter, or a foster care facility. CPS and caregivers are required to arrange all educational, social, medical, dental, and therapeutic services needed by the child.

When children are removed from their homes, a court has oversight of the case. CPS continues to evaluate the family's situation, and to provide all needed educational, social, medical, dental, and behavioral health services. CPS conducts assessments of relatives or other significant and close relationships to the family.

Throughout this process, CPS staff engages in permanency planning on behalf of the children to ensure each child exiting from DFPS care is placed in an appropriate,

permanent setting. If parental rights are intact, CPS provides ongoing services to the parents until the family is reunited and DFPS' legal responsibility is ended, or until the court approves another permanent living arrangement for the children. If a child cannot be returned to a parent, then CPS makes every effort to identify a caring and committed relative or other caregiver who is willing to assume legal custody of the child.

CPS engages with community partners to help develop and support implementation of CPS programs and policies. CPS employs a Community Affairs Liaison and regional community engagement staff to facilitate collaborations with community partners across the state. CPS actively continues to encourage ongoing community partnerships and community involvement in multiple ways that include:

- Engaging families and consumers involved in the child welfare system at all decision-making levels;
- Strengthening opportunities for volunteers to assist DFPS through effective recruitment and retention strategies;
- Securing meaningful youth voice and engagement at all decision-making levels; and
- Developing and strengthening partnerships with post-secondary institutions to support program improvement, evaluation, and additional efforts taken on by DFPS.

Planned Actions

Enhancing Family-Centered Safety Decision-Making

The March 2008 Children and Families Services Review, DFPS' internal review of the Investigation and FBSS programs, and consultation from the National Resource Center for Child Protection Services indicated the need to further strengthen or enhance family-centered safety decision making protocols in all stages of service. Stages of service include investigation, FBSS, and conservatorship.

The goal of Enhanced Family-Centered Safety Decision-Making (EFCSDM) is to support staff in making sound safety decisions for children in all stages of service. EFCSDM will be accomplished by strengthening and putting into practice child safety decision-making protocols using a family-centered approach. This is a continuous quality improvement process that began in 2009 and helps staff:

- Better identify when children are safe *vs.* unsafe;
- Better understand the family changes that must occur to keep children safe, resulting in improved matching of appropriate services to children and families;
- Have an improved understanding of safety as it relates to permanency; and
- Support family-centered values.

Staff in all stages of service has been trained on the core principles of EFCSDM. The concepts have been incorporated into Basic Skills Development to ensure that new staff receives the same information. The principles are now being incorporated into the CPS Practice Model.

Implementing Permanency Roundtables

CPS works to provide permanent placement for children who cannot remain safely in their own homes. There are challenges in getting some children in CPS' care into permanent homes. Permanency Roundtables (PRTs) are an intervention strategy to facilitate the permanency planning process by identifying realistic solutions to permanency obstacles for children. To help address these challenges, in June 2012, CPS initiated PRTs and finalized statewide implementation in February 2014.

The Texas model for PRTs is a case consultation with an internal team of caseworkers, supervisors, program directors, program administrators, and other agency subject matter experts to brainstorm and create child-specific action plans to achieve permanency for children. In many cases, a child will be placed with a relative or kinship caregiver, who becomes permanent managing conservator (an individual or entity to be permanently legally responsible for a child). A CPS staff member specializing in permanency issues will facilitate the PRT meetings and will also be responsible for monitoring that tasks assigned out of those meetings are completed.

Implementing Trauma-Informed Care Initiative

Most children entering the child welfare system have been through painful and distressing experiences. As a result, they may have emotional and behavioral responses that seem inappropriate for their current situation. When working with these children, it is important to be sensitive to the ways in which the trauma they have experienced affects their current behavior. In recent years, best practices for child protective services have begun to incorporate the concept of trauma-informed care; in this way, all people who serve a child in care are informed about the trauma and the conditions and needs the trauma may cause.

DFPS formed its Trauma-Informed Care Workgroup (TICW) in October 2011 as part of the Trauma-Informed Care Initiative. The goal of this initiative is to develop and implement an integrated approach to trauma-informed care that maximizes agency resources and improves outcomes for the children and families served by CPS.

A trauma-informed child- and family-serving system is one in which all parties recognize and respond to the varying impact of traumatic stress on those who have contact with the system, including youth, caregivers, and service providers. A service system with a trauma-informed perspective is one in which service providers:

- Routinely screen for trauma exposure and related symptoms;

- Use a consistent set of culturally appropriate, evidence-informed assessments that address well-being and use culturally appropriate treatment for traumatic stress and associated mental health symptoms;
- Make resources available to clients on trauma exposure, its impact, and its treatment;
- Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma;
- Address parent and caregiver trauma and its impact on the family system;
- Emphasize continuity of care and collaboration across child-serving systems; and
- Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress.

The TICW is comprised of both internal and external stakeholders, including several state and nationally known trauma-informed care experts serving as advisors. A trauma-informed system incorporates the child's and family's story and the child's developmental level while establishing an evidence-based approach to policies, training, leadership, and service practice. In spring of 2012, a strategic plan was developed to guide this important effort, and implementation of the plan will continue in the statewide strategic planning period of 2015–2019. Workgroups comprised of internal and external stakeholders will continue to meet to achieve the goals and tasks to improve outcomes of children in the child welfare system.

To further efforts to promote child safety and well-being, reduce the harmful impact of abuse and neglect on children, and decrease the traumatic experiences for children and their families, the workgroup will continue to recommend improvements to DFPS regarding integration of trauma-informed practices within CPS. The TICW will also provide oversight of approved implementation strategies. DFPS expects the transition to a full trauma-informed system of care to continue during the 2015–2019 planning period.

Reducing Disproportionality of Outcomes for Children

African-American and Native American children and their families are disproportionately represented in the CPS foster care system, in Texas and nationally. For example, in Texas, in fiscal year (FY) 2013, African-American children made up 11.6 percent of the child population; by contrast, they were 19.4 percent of all children removed from their homes, and 25.0 percent of all children waiting for adoption.

Throughout policy, practice, and all initiatives, DFPS continues its commitment to reducing the disproportionate representation of African-American and Native American children in the CPS system. Since DFPS' commitment to reducing disproportionality began in 2004, CPS achieved the following accomplishments.

- More than 3,000 youth, community members, staff, providers, and others have participated in Undoing Racism© training.

- More than 4,100 CPS staff have participated in the "Knowing Who You Are" racial and ethnic identity development training.
- More than 20 town hall meetings have been conducted across the state, encouraging community feedback and partnerships for improving CPS operations and relationships with the community.

DFPS will continue its efforts to reduce disproportionality through collaboration with the Health and Human Services Commission's Center for Elimination of Disproportionality and Disparities.

8.3.2 Implementing Foster Care Redesign

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

- Improve access to effective services across systems for behavioral health, including prevention, treatment, and recovery services, and integrate physical and behavioral health services.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.
- Work closely with faith- and community-based organizations to assist people in applying for nutrition, medical, monetary, and other assistance.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.

Discussion

When children have to be placed outside their homes, and no appropriate non-custodial parent, relative, or close family friends are available for the court to award temporary legal possession, the court will ask Child Protective Services (CPS) to place the child temporarily in a foster care setting. Though CPS strives to ensure quality services for children placed in foster care, these children may experience multiple placement changes over time due to lack of options for a child to safely exit DFPS care into an appropriate, permanent setting. CPS has developed several

initiatives to increase placement options which will enable a range of choices to match to individual child needs.

For many years, Texas' child welfare system has faced the challenge of having some children in foster care placed outside of their home community. Frequently, the resources for serving these children in foster care are concentrated in specific areas of the state, while other areas may have few or no resources. A lack of placement resources in the right place may result in several placement moves for children in foster 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.

Additionally, many foster care providers contract for a specific placement type (e.g., a child-placing agency or a general residential operation such as residential treatment centers) to serve children with specific service needs. Very few providers offer a continuum of placement types that can accommodate the changing service needs of children.

Planned Actions

Since January 2010, DFPS has been engaged in an effort to improve outcomes for children and youth residing in paid foster care and their families, known as Foster Care Redesign. Foster Care Redesign's goal is to create sustainable placement resources in communities that will meet the needs of children and youth in foster care, using least restrictive (most family-like) placement settings.

The redesigned foster care model will support the achievement of the quality indicators listed below.

- First and foremost, all children and youth are safe from abuse and neglect in their placement.
- Children are placed in their home communities.
- Children are appropriately served in the least restrictive environment that supports minimal moves.
- Connections to family and others important to children are maintained.
- Children are placed with siblings.
- Services respect the child's culture.
- To be fully prepared for successful adulthood, children and youth are provided opportunities, experiences, and activities similar to those experienced by their non-foster care peers.
- Children and youth are provided opportunities to participate in decisions that impact their lives.

To design systemic changes that would better support the accomplishment of the eight indicators listed above, stakeholders recommended that DFPS change the manner in which it purchases, contracts, and pays for foster care and other services.

Change the way DFPS procures: Move from procuring residential and other purchased services through an open enrollment process, service by service, to procuring a full continuum of services from a single source continuum contractor through a competitive process.

Change the way DFPS contracts for foster care and other purchased services: Move from efforts based contracts where the agency defines the "how" each service will be delivered to a performance-based contract where there are:

- Financial incentives and remedies tied to permanency outcomes,
- Additional performance measures related to well-being outcomes, and
- A single entity that is held accountable for the outcomes children and youth experience while in paid foster care.

Change the way DFPS pays the provider of services: Move from a system that pays providers based on multiple rates to a single blended rate that is paid to the provider for every day of care the child receives.

- De-link the service levels from the rates to move to a system that rewards improved well-being outcomes.
- Provide a separate allocation of funds for other services to children in foster care and their families.

Senate Bill 218 (82-R) directs DFPS to implement the new foster care model in accordance with the DFPS Foster Care Redesign Report. DFPS signed the first single source continuum contract as a part of this redesign effort with a vendor on December 21, 2012. This vendor is responsible for ensuring the full continuum of care for both regions 2 and 9, which consists of 60 counties, including Wichita Falls, Abilene, San Angelo, Midland, and Ector counties.

- February 1, 2013: Contract was executed.
- February 1, through August 25, 2013: Start-up phase began.
- August 26, 2013: Vendor received first referral.

DFPS signed the second single source continuum contract with a vendor on December 16, 2013, with this vendor responsible for ensuring the full continuum of care for a seven-county area of Region 3 that includes: Erath, Hood, Johnson, Parker, Palo Pinto, Somervell, and Tarrant counties.

- January 1, 2014: Contract was executed.
- January 1, 2014: Start-up phase began.
- July 1, 2014: Vendor is anticipated to serve the first child under the new model.

DFPS has contracted with the University of Chicago's Chapin Hall to assist with the evaluation of Foster Care Redesign. A unique aspect of Chapin Hall's work is the use of prospective, rather than retrospective, analysis of performance metrics. Historical data were used to establish baselines for the four outcomes noted above. The data are also used to make projections about the numbers of children who will be in care and the number who will be entering care during a 24-month performance period. Those projections are very important because they provide the redesigned system with information about what should be happening to a specific number of children who are in care or who have entered care during the performance period. If performance is not on a trajectory to meet expectations, systemic or operational changes can occur before the performance period ends. In other words, changes can be made to something as it is happening, rather than waiting and not being able to change something that has already happened.

As part of the outcome evaluation, performance findings will contribute to a continuous quality improvement process, with reports on outcome evaluation data beginning in 2014.

8.3.3 Improving and Effectively Targeting Adult Protective Services

Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.

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

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

- Ensure the safety and well-being of Texans in facilities regulated by, operated by, or provided via contract with the state, as well as those served in their homes.
- Improve detection of potential risk of harm to vulnerable children and adults in the residential settings regulated by, operated by, or provided via contract with the state and ensure that appropriate services are offered and provided when abuse, neglect, or exploitation is suspected or occurs.
- Work with law enforcement to support prosecutions of people suspected of criminal abuse, neglect, or exploitation.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Discussion

Adult Protective Services (APS) is often the last or only available option to help alleviate or prevent further maltreatment of people ages 65 and older and people who have disabilities. Changes in client demographics and the social services delivery system affect both the APS In-Home and Facility programs. To address these changes, APS must continually examine current and alternative practices to determine the most efficient ways to improve the effectiveness of its investigations and services.

Population Growth

The Texas State Data Center estimates that baby-boomers (people born between 1946 and 1964) will contribute to a 133-percent increase in the number of people ages 65 and older between 2015 and 2040. Similarly, the adult population with disabilities, including people with mental illness, is expected to increase by 55 percent between 2015 and 2040. The sharp increase in the number of people ages 65 and older will result in a significant increase in the already-growing demand for APS services. Texas' existing infrastructure for community-based long-term care and services may not be able to meet the future needs of a growing population. Adequate infrastructure is necessary to provide ongoing support to clients after APS provides short-term intervention services.

The number of APS completed In-Home investigations rose by almost 28 percent between FY 2008 and FY 2012. A clarification of APS abuse, neglect, and financial exploitation definitions took effect in FY 2013 and led to a 21-percent decrease in investigations that fiscal year. However, the number of investigations is once again rising in FY 2014. In the first half of FY 2014, the number of completed in-home investigations rose by approximately 11 percent as compared to the same period in FY 2013. As the number of clients eligible for APS services continues to increase, so will the demands on caseworkers. The specific challenges that face the APS client population include the recidivistic cases that cannot be easily resolved. These cases include clients who live with severe physical impairments, mental illness, or dementia, and many of them also live in chronic poverty.

APS intervention cannot resolve the root causes of poverty, mental illness, or progressive dementia. Many clients with these issues will continue to have an ongoing need for APS to serve as their safety net.

Improving and Targeting the APS In-Home Program

The APS In-Home Investigations and Services program (In-Home program) investigates reports of abuse, neglect, and financial exploitation of people ages 65 or older and people who have disabilities, and it provides or arranges for protective services as needed. In FY 2012, efforts to improve effectiveness and target APS services to those most in need led to changes in the In-Home program rule. These

changes clarified the definitions of abuse, neglect, and financial exploitation, and they raised the standard of conduct for paid caregivers.

The In-Home program also examined current and alternative casework practice models. A new casework model was developed based on best practice research. The new practice model, called SHIELD (Strategies that Help Interventions and Evaluations Leading to Decisions), includes a safety assessment to determine the need for emergency services, a risk of recidivism assessment to guide decisions on the level and intensity of services needed, and strengths-and-needs assessment to guide decisions about specific service needs and effective service planning. The SHIELD model, which will be implemented in FY 2015, will:

- Target services to those most in need,
- Provide decision-making tools that further empower caseworkers,
- Help workers and supervisors provide interventions based on safety and risk of recidivism,
- Focus efforts on the clients most at risk for coming to the attention of APS in the future, and
- Guide decision-making on the level and intensity of services in valid cases.

APS collaborates 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 to strengthen community resources for clients. APS is continually communicating with stakeholders to determine ways that it can best target services to those individuals in need who are ineligible for services from other agencies, and those for whom an APS investigation will alleviate the root cause of their harm.

Need for Long-Term Solutions

Many In-Home clients are referred to APS because they have fallen into a state of self-neglect. APS is only authorized to fund short-term emergency services. In situations where longer-term services are needed, APS makes referrals to available, appropriate local service providers or other state agencies.

Many referrals to APS are due to a lack of a consistent continuum of care, causing people ages 65 and older and people with disabilities to require repeated short-term, emergency assistance from APS. The percentage of clients referred twice within the same year grew from 13 percent in FY 2008 to 15 percent in FY 2013.

APS Facility Investigation Program Changes

The APS Facility Investigation program provides objective, unbiased investigation reports on allegations against facilities such as state-operated and private providers of services for persons with intellectual disabilities, developmental disabilities, or

mental illness. The reports provide the basis for providers to take action to protect clients, and for DFPS to make referrals of confirmed perpetrators to the Employee Misconduct Registry (EMR). The EMR is a database maintained by the Department of Aging and Disability Services (DADS) that contains the names of persons who have committed certain types of abuse, neglect, or exploitation that make them ineligible to work in certain facilities or agencies.

APS closely coordinates the development of its policy and practice with DADS, the Department of State Health Services (DSHS), and Disability Rights Texas. Recent efforts have included:

- Development of a new database to coordinate EMR cases across agencies;
- Continued focus on meeting requirements of the federal Department of Justice (DOJ) Settlement Agreement to protect residents of State Supported Living Centers (SSLCs); and
- Coordination with the Health and Human Services Commission (HHSC), DADS, and DSHS on development of policy resulting from the move toward having managed care organizations provide mental health services and services for people with intellectual and developmental disabilities.

In FY 2013 APS completed a process analysis of the Facility Investigations program and it has implemented recommendations to centralize some program functions and to improve communication. These changes will lead to greater consistency statewide in facility investigations, which will better protect vulnerable clients.

Planned Actions

Monitoring Implementation of SHIELD and Identifying Additional Improvements to Case Practice Model

APS will monitor and evaluate the implementation of the SHIELD In-Home casework practice model during the planning period. This will result in identification of potential gaps in the new service delivery model and additional areas of improvement in policy and staff skills.

SHIELD includes a new service-delivery practice called Intensive Case Services (ICS). APS will review and evaluate the ICS service-delivery model to determine the types of services being provided to clients and how those services are being provided. The focus of the evaluation will include a review of the:

- Effectiveness of how APS purchases client services,
- Flexibility of the APS contracting staff to improve the process of purchasing client services, and
- Skills training for APS caseworkers and contracting staff on best use of agency resources to protect clients.

This process review will determine possible enhancements to contracting and service provision policy. It will also help to determine what additional training staff may need in order to implement those enhancements. The resulting changes will help APS to better serve APS clients while ensuring accountability for the best use of limited state resources.

APS will adapt its performance management system to effectively evaluate cases completed within the new In-Home casework practice model. This will ensure that a high standard is set for casework practice and accountability, and that continued program improvement is made.

APS will also assess the consistency with which SHIELD and the ICS processes, as well as any new improvements being proposed during the planning period, align with existing state statute. This will help to inform any changes that may be needed in statute.

Improving the APS Facility Investigations Program

The services and service-delivery system for individuals with intellectual and developmental disabilities are rapidly evolving. The introduction of managed care into this system and the system for mental health services will further this evolution. Even before the introduction of managed care, the evolution of the systems was creating jurisdictional and practice model questions for APS.

APS will continue to work collaboratively with HHSC and partner agencies during this planning cycle to come to cross-agency agreements regarding which programs should be subject to APS's facility investigations of abuse, neglect, and exploitation. APS will also explore how to improve its casework and reporting model to improve the appropriateness and efficiency of investigations for different types of service providers. Finally, APS will continue to work with DADS and the DOJ monitoring teams to ensure investigations in SSLCs are compliant with Settlement Agreement provisions on abuse, neglect, and exploitation.

8.3.4 Reducing Hold Times While Maintaining Quality at Statewide Intake

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

- Improve detection of potential risk of harm to vulnerable children and adults in the residential settings regulated by, operated by, or provided via contract with the state and ensure that appropriate services are offered and provided when abuse, neglect, or exploitation is suspected or occurs.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.
- Recruit, retain, and motivate the health and human services workforce by investing in employees with exemplary performance and by providing opportunities for professional development and advancement.
- Use technology and other means to maximize work efficiency and eliminate costly maintenance and repair on unneeded or underutilized office space.

Discussion

DFPS will be challenged to meet increasing demands, 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. These challenges include increased contact volume demands for Statewide Intake (SWI). SWI takes reports on abuse, neglect, and exploitation of children, people ages 65 and older, or people with disabilities. Reports of abuse, neglect, and exploitation will increase in accordance with the size and demographics of the population.

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 expeditiously.

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) routes calls received to Intake Specialists as they become available. The ACD system requires routine maintenance and upgrades to handle the load increases expected in this planning cycle. 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. Constant updating and expansion of systems that support the SWI call center is essential. The average hold time on the English queue for FY 2011 was 7.3 minutes. Through May 2012 the FY year-to-date average hold time was 9.1 minutes. The Legislative Budget Board performance measure target for SWI average hold time for the 2012-13 biennium is 8.7 minutes (+/-5 percent).

Planned Actions

Enhanced Continuity of Operations

In August 2012, SWI began a telework initiative, with 20 staff teleworking full-time. In December 2013 a computer refresh replaced 245 SWI desktops with laptops. This enabled the major expansion of teleworking. As of May 2014, approximately 230 SWI staff will work all or some of their shifts from home, thereby achieving SWI's stated goal of having 50 percent of all work hours performed via telework by January 2015. In addition to improving worker morale, SWI can now more easily maintain business continuity in situations such as weather-related events, disaster recovery events, and when travel is restricted due to a pandemic.

Provide Ongoing System Maintenance

Ensuring SWI's capacity to handle the increased number of callers and increased demand on its equipment continues to be a challenge. The ACD system may need to be replaced as it nears its end of life status, targeted for April 2016. More hardware (e.g., laptops and phone lines) may need to be added to maintain the current functionality and to handle anticipated increases in volume.

8.3.5 Enhancing Child Safety through Effective Child-Care Regulation

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

- Create a regulatory environment that fosters the health, safety, and opportunities of Texans while ensuring a pro-business approach that supports accountability and innovation.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.

Discussion

Child Care Licensing (CCL) establishes and enforces standards of care for children who attend child day care operations or who reside in 24-hour residential child care facilities. In Texas, there are diverse views regarding what constitutes appropriate care in day care or residential child care operations and the degree of regulation needed to enhance the safety of children in out-of-home care. CCL is continually challenged to balance regulatory responsibility with the availability and affordability of care. Additionally, in order to provide child care in Texas, unless otherwise exempt as defined in the Human Resources Code, no person may operate a child care facility without a permit issued by DFPS. Risks to child safety exist when children are cared for in illegally operating child care settings, as these providers typically do not offer the basic health and safety protections that regulated child care provides.

CCL is also responsible for investigating allegations of abuse or neglect in child care operations, inspecting and monitoring operations for compliance with minimum standards of care, and taking corrective or adverse actions when necessary. Having a uniquely qualified, well trained front-line workforce is a critical component to ensuring the protection and safety of children in Texas day care and residential child care operations.

Minimum Standards of Care

CCL is statutorily mandated to review all rules and standards for child care operations every six years. Accordingly, CCL routinely evaluates and makes needed changes to specific standards based on legislative requirements, stakeholder input, and staff recommendations. A review can result in no changes, some changes, or substantive changes to the minimum standards.

The most recent comprehensive review for child day-care standards was conducted in 2010, and the most recent comprehensive review for 24-hour residential child care standards was completed in 2007. In 2010, based on a CCL-identified need to ensure that the 24-hour residential child care standards were having the intended outcome for children in care, CCL conducted an additional review of those standards. The next statutorily required review of minimum standards for both day care and residential child care operations is due in 2016 and will begin in 2015.

Illegal Day Care Operations

Unregulated care consists of persons providing child care services illegally, operating without the required permit, training, background checks, and ongoing regulatory oversight that help ensure the provider's compliance with minimum standards of care. While unregulated child day care is often a cheaper option for parents and other caregivers, unregulated providers typically have not completed training such as first aid and cardiopulmonary resuscitation, have not completed and

passed a background check, and do not adhere to limits on the maximum numbers of children allowed per caregiver. Without these and other basic protections required in regulated child care operations, illegally operating child care is often a dangerous situation for children. With its ongoing focus on child safety, CCL will continue devoting resources to finding illegally operating providers and either assist them in becoming regulated or shut them down.

Safety in Residential Child Care Operations

CCL regulates 24-hour residential child care operations which are responsible for the care, supervision, education, and treatment of children placed with them. Some children live in residential child care operations due to being abused, neglected, or because of other family circumstances that didn't permit the child to live in his or her own home. In fiscal year 2013, there was a marked increase in the number of child fatalities occurring in residential child care operations. In response, DFPS developed the DFPS Safety Plan for Children in Foster Care, which outlines immediate and long-term improvements designed to keep children safe and address preventable deaths in care.

Basic Skills Development Training

CCL staff provides regulatory services for over 35,000 facilities with a combined capacity of approximately 1.1 million children in Texas, and the number of families and children in Texas is anticipated to continue increasing in coming years. Although director and manager tenure is considerable, and experienced staff stays in the CCL program, training new employees is a challenge with existing resources, the current curriculum, and the current methods of delivery. Because preparing new staff is foundational to quality casework and appropriate regulation, CCL's Professional Development Division is redesigning the basic skills training course for both the day care and residential child care licensing programs.

Planned Actions

Review of Minimum Standards

The statutorily required review of all child day care and all residential child care minimum standards will fall within the strategic planning timeframe of 2015–2019, with stakeholder involvement starting in 2014. CCL begins preparing well in advance of the required minimum standard review and heavily encourages stakeholder involvement in the process. CCL will make diligent efforts to engage all levels of stakeholders, including parents, providers, child advocates, DFPS staff, and legislative leadership in providing input and comments. In the course of reviewing all standards as required by statute and in conjunction with stakeholders, CCL will assess standards related to the social and emotional development of children, promoting children's safety and healthy development, and responding to behavioral health needs of children in out-of-home care.

CCL will host stakeholder meetings in various cities in Texas, post proposed changes to minimum standards on its website, and continue to maintain an electronic comment web-form for its public and provider website for those participating in the review-and-comment process. In addition, CCL will continue to maintain dedicated email boxes to receive input from stakeholders. Comments on any proposed changes will be taken via online submission, email, and standard mail. Notification of the comment period will be disseminated to child care providers via mail, email, and the DFPS website.

Continued Reduction of Illegal Day Care Operations

From the 83rd Legislature, Regular Session, 2013, DFPS received 44 additional positions to address the risk to children being cared for in illegal day care operations. The additional staff enables CCL to proactively find illegally operating day care providers, investigate them, and then take appropriate action, whether it is to assist them to apply for a permit and become regulated, or to take steps to close the operation. Between November 2013 and February 2014, CCL staff investigated over 400 illegal operations. Determining that 88 of them posed an immediate threat to children, CCL closed those operations immediately. During this time, CCL also assisted over 70 illegally operating day care providers to apply for the statutorily required permit to provide day care services in Texas. To reinforce child safety, CCL partners with local communities to increase public awareness regarding the importance of parents and caregivers choosing regulated child care over illegal day care operations. Community outreach efforts include providing campaign materials and information about the dangers of illegal day care to local health departments, schools, libraries, child advocacy centers, law enforcement offices, and at child care provider conferences. CCL expects continued reductions in illegal day care operations and increases in public awareness during the 2015–2019 strategic planning timeframe.

Enhanced Safety in Residential Child Care Operations

DFPS conducted an analysis of child fatalities that occurred in foster care during fiscal year 2013, looking for patterns or risk factors related to these deaths. Results of that analysis reflect that there is a higher level of risk for very young children and children with primary medical needs, who cannot live without mechanical supports or the services of others because of non-temporary, life-threatening conditions. Furthermore, because 90 percent of children in the Texas foster care system are placed with private providers, DFPS examined the way it regulates, interacts with, and monitors residential child care providers.

DFPS has communicated to all child placing agencies (CPAs) the critical need to ensure child safety, particularly for children with special needs, and the agency's expectations for those who accept children into their care. As part of a

comprehensive, coordinated DFPS response, CCL is proposing changes to the Texas Administrative Code, including requirements for:

- Limitations on the number of children with primary medical needs who can be placed in one foster home;
- A more comprehensive foster home screening process by CPAs; and
- Increased CPA unannounced visits to the foster home to evaluate stressors in the home, changes to the household, and the appropriateness of supplementary caregivers for the children.

CCL has developed safety recognition cards, printed in spring 2014, for CPA staff to use when visiting a home. These palm-sized cards have a checklist of safety reminders and other information for appropriate care for children with primary medical needs. CCL will deliver the cards to the CPAs and will discuss the safety reminders with CPS case managers during future monitoring inspections.

CCL will also review the availability and use of emergency respite care as alternate and respite care is currently being offered but not required by CPAs. This review may result in additional rule changes and potential contract amendments to further enhance the protections and safety of children in residential child care operations.

Implement Holistic Approach to Professional Development

CCL is undertaking a redesign of its Basic Skills Development (BSD) program, with a targeted completion date of August 2015. The goal of a redesigned BSD is to provide a holistic approach to training and retaining new staff. The effort will improve how new staff receive instruction before entering the classroom, during face-to-face instruction, and after the formal training experience ends. The redesigned approach will include computer-based training, reformatted classroom instruction, and a formal mentoring process both before and after the trainee participates in the training classroom. The newly designed training approach will also include a more comprehensive assessment of skills throughout the BSD experience so that trainers and supervisors can focus instruction on a trainee's areas of weakness when needed. This approach also allows supervisors and managers to determine whether a struggling new employee is the right fit for child care regulation.

8.3.6 Enhancing Interagency Partnerships, Coordination, and Data-Sharing

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

- Emphasize health promotion, disease prevention, early intervention, and primary care, in a quality-oriented, electronically enabled, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Improve access to effective services across systems for behavioral health, including prevention, treatment, and recovery services, and integrate physical and behavioral health services.

Strategic Priority: Encourage partnerships and community involvement.

- Continue to enhance interagency partnerships, coordination, and information-sharing in addressing clients' complex needs.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.

Discussion

DFPS serves children, people ages 65 and older, and people with disabilities who are often recipients of services from other state agencies. Collaborating with other state agencies to align goals, priorities, and resources for the complex needs of a mutual client population minimizes duplication of efforts and provides increased protection and support for vulnerable Texans.

Coordinating Services for Children

DFPS relies on agency and community collaboration in the area of substance abuse treatment to improve child safety and to support families. DFPS collaborates with the Department of State Health Services (DSHS) to expand substance abuse and provider treatment capacity to help keep families together. DFPS also works with the agencies to develop training for Child Protective Services caseworkers on fetal alcohol spectrum disorders.

DFPS collaborates with agencies that serve children and youth and children involved with both agencies to coordinate services that best meet their needs. DFPS collaborates with the Department of Aging and Disability Services (DADS)

Guardianship Program to ensure the well-being and safety of youth with special needs and youth who are aging out of foster care.

Planned Actions

DFPS will continue to collaborate with other agencies and stakeholders to improve and protect clients. DFPS will:

- Work with the Texas Alliance for Drug Endangered Children to create and maintain teams to support and protect children endangered by drug use;
- Work with DSHS and the Texas Supreme Court Children's Commission to establish new family and drug-treatment courts;
- Maintain communication with stakeholders from the Health and Human Services Commission (HHSC) and STAR Health, a medical care delivery system for children in foster care, about services, issues, and areas for improvement; and
- Work with the Texas Workforce Commission to develop an interface to manage the expenditure of funds for day care services to ensure they fall within budget and are properly authorized.

The APS program will continue collaboration with DADS, DSHS, Disability Rights Texas, and HHSC to discuss the scope of facility investigations and sharing reported information with other agencies. APS will work with DADS and HHSC to clarify jurisdiction in APS cases of abuse, neglect, and exploitation as they relate to the implementation of Senate Bill 7 (83-R), since this was not specifically addressed in the legislation.

8.4 Internal Challenges and Opportunities

8.4.1 Continuous Improvement of Business Processes

GoMobile Business Model

By capitalizing on current tools and exploring ways to take advantage of new technological developments, DFPS constructed a business model, entitled GoMobile, to support staff working more flexibly and efficiently.

The majority of DFPS caseworkers are mobile, spending 60 to 70 percent of their time with clients, providers, and facilities in the field, requiring extensive travel and interaction with many people. By providing a completely mobile technology package, GoMobile offers additional flexibility in the locations where caseworkers can complete their documentation or other administrative tasks and removes the

need for daily office check-in. This work environment encourages utilization of technology to support completion of other business tasks, such as: meeting participation, electronic transmission/retrieval of information, form completion, printing/scanning/copying, and consulting with supervisors in real time while in the field. The adoption of the GoMobile work model reduces the amount of space needed for offices and thus allows for consolidation and cost savings, while increasing productivity. The project had a phased completion schedule, with most goals to be completed by FY 2014. Goals include:

- Increasing the number of casework staff designated as "mobile,"
- Reducing travel costs by two percent,
- Reducing footprint through consolidation of offices,
- Reducing footprint by configuring office space for mobility, and
- Increasing retention and job satisfaction.

DFPS information technology staff works to ensure safety and privacy of data and devices, as discussed below in section 8.5.3, Addressing Infrastructure Needs.

Streamlining Contract Management

DFPS participates in the Health and Human Services (HHS) System's HHS Enterprise Contract Management Workgroup, led by the Health and Human Services Commission's Procurement and Contracting Services. This group, in conjunction with each agency's chief operating officer, works to improve contract management across the HHS System, streamlining and standardizing where appropriate.

DFPS will undertake multiple activities in support of the HHS System's efforts to streamline administrative requirements:

- Participating actively in the workgroup meetings and sharing information with DFPS agency stakeholders impacted by anticipated changes;
- Adding HHS System-endorsed changes to the DFPS Internal Contract Improvement Workplan and the Contract Oversight and Support workplan, aligning policies and procedures with Improvement Plan recommendations, which will ultimately allow streamlined processes for contract management staff and contractors;
- Improving the DFPS Contract Handbook to promote compliance with the Enterprise Contract Management Manual, which will standardize policies across all HHS agencies; and
- Enhancing agency processes to comply with the legislatively mandated contract management training and certification, and coordinating with the Enterprise to ensure all necessary DFPS employees obtain the training and certification required.

8.4.2 Maintaining and Developing the Workforce

Staff retention is critical to improving service delivery and minimizing the effects of staff turnover. Using employee feedback gathered through multiple sources, DFPS continues to take action to decrease staff turnover.

Over the past few years, overall agency turnover has increased from 15 percent in FY 2009 to 19 percent in FY 2013. The highest turnover rates in FY 2013 were Child Protective Services (CPS) Family-Based Safety Services (FBSS) workers at 30 percent and CPS Investigators at 33 percent. There are also areas of the state that see higher turnover than others: DFPS Region 9 (Midland/Odessa) at 29 percent, and Region 11 (Rio Grande Valley) at 24 percent in FY 2013.

Employee exit surveys and the Survey of Employee Engagement indicate that employees are disappointed with several aspects of employment at DFPS:

- Working conditions, such as safety, work-related stress, or workload;
- Supervisor-employee relationship issues; and
- Pay and benefits.

DFPS currently recruits for DFPS employees in several different ways, with a view toward increased retention of people who are hired. The strategies detailed below are designed to identify the best applicants to deliver services and to improve both employee satisfaction and retention.

- **Internet Presence—**By clicking on the "Jobs" link from the agency website (http://www.dfps.state.tx.us), users are taken to the "Come Work for Us" page that includes CPS job preview video and written realistic job previews for CPS jobs. The site also includes a screening test that asks applicants questions to help them decide if CPS is the right fit for them prior to applying.
- **Pre-Employment Testing—**Qualified prospective employees for Adult Protective Services (APS), CPS, and Child Care Licensing (CCL) receive a pre-screening test to assess skills and performance capabilities and a behavioral descriptive interview guide, geared at assessing how each candidate would respond to real life work situations.
- **Targeted Degrees—**DFPS is required by Senate Bill 758 (80-R) to target recruitment efforts to individuals who hold a bachelor's degree or advanced degree in at least one of the following academic areas: social work, counseling, early childhood education, psychology, criminal justice, elementary or secondary education, sociology, and human services. House Bill 753 (82-R) also requires DFPS to give preference to candidates with masters or bachelor degrees in social work when hiring entry level caseworkers.

- **Extra Pay for Social Work Graduates—**New hires with a Masters of Social Work receive an additional seven percent in starting salary, while new hires with a Bachelors in Social Work receive an additional three percent in starting salary.
- **Bilingual Recruitment—**DFPS recruits bilingual workers by using consistent testing for bilingual skills and has a consistent policy in place for bilingual pay.

DFPS currently seeks to retain DFPS employees in several different ways.

- **Stipends for CPS Investigators and Investigative Supervisors—**DFPS provides a $5,000 annual stipend to investigation caseworkers and investigation supervisors, as authorized by the General Appropriations Act (79-R).
- **Enhanced Rookie Year On-Boarding—**Supervisors welcome employees before their first day on the job and provide targeted support throughout the first employment year.
- **First Years Recognition Program—**This effort recognizes new employees' tenure during each of their first four years with DFPS by awarding tenure certificates.
- **Basic Skills Development Program—**DFPS has focused training programs based on the program area to ensure that caseworkers are prepared to perform all their assigned tasks.
- **Certification Program—**Direct delivery staff and their supervisors earn pay increases by achieving specific amounts of tenure, completing approved training programs, and maintaining satisfactory performance.
- **"DFPS LEADS (Leadership Excellence • Advancement • Distinction • Support) Program"—**This training program provides supervisory and manager-level employees an integrated competency-based training curriculum. This curriculum is designed to support a continuum of learning and skill development from beginner to advanced management levels.
- **Focused Retention—**DFPS provides the following focused retention activities for jobs with high turnover, high caseloads, and high vacancy rates:
  - Providing locality pay in some areas of Texas;
  - Bringing program/division teams together to help with workload in specific areas;
  - Paying a percentage of earned overtime for certain staff; and
  - Adding caseworker staff, as the budget and full-time equivalent cap permit, to reduce caseloads.

8.4.3 Addressing Infrastructure Needs

Mobile technology has shown significant growth in access to information, usability of information, and productivity gains. Advancements in many areas, including network bandwidth, smart-phone capability, mobile applications, mobile printer/scanner/copy

devices, and tablet personal computers (tablet PCs), have enabled DFPS to transition to a direct delivery workforce that is mobile. These improvements raised important questions.

Enhanced Use of Mobile Technology and Impact on Office Space Needs

Currently most casework employees are issued tablet PCs which allow them to access the DFPS network to perform their work while in the field. Each of these mobile employees receives a smartphone enabled with tethering service that can connect the tablet PC to the DFPS Virtual Private Network without the need for connection via data cable. DFPS continues to expand wireless technology services within DFPS offices as the GoMobile model is applied to office space.

The traditional work model is built around office-based on-site technology and the need for frequent returns to the office to document case actions, confer on casework decisions, and meet with clients. 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. As technology and business processes have evolved, there has been a decreased need for DFPS employees to return to the office. In view of this evolution, DFPS has developed a space template that provides shared space for casework staff, while increasing availability of storage space and interview rooms. While initial conversion to a mobile space template may result in an increase in square footage, ultimately costs are avoided with the addition of new staff to individual locations. In those instances, traditional floor plans may require new office space when staff is added to a location; after offices are converted to the mobile template, there may not be a need to seek more space when FTEs are added.

Security of Information and Technology Infrastructure

Safeguarding the information and technology infrastructure of DFPS is and will continue to be an issue of the highest priority. As a year-round, around-the-clock operation supporting health and well-being, including in some emergency situations, DFPS handles personal, protected information and must maintain the confidentiality, integrity, and availability of information resources to accomplish its mission. Information and the infrastructure that houses it, including mobile devices used by 80 percent of DFPS staff, must be kept secure at all times and in all places.

With the growth of the Internet, large computer networks are facing increasing threats, in both the number and the severity of attacks, and state agencies such as DFPS are no exception. Attackers may be seeking profitable or confidential information, furthering an anti-government agenda, or simply attempting to cause mischief. Security vendors are constantly adapting products to address diverse malware technologies, but rising numbers of breaches occur despite their best

efforts. Successful attacks can cause security breaches, network service outages, or corruption and loss of data.

Advances in mobile technology and social networking offer new opportunities to collaborate and create efficiencies to enhance the productivity of DFPS programs, especially since more than half of the workforce at DFPS is mobile. Unfortunately, attackers now employ sophisticated capabilities and exploit these new platforms. To support frontline caseworker staff and public information campaigns, DFPS uses multi-layered security strategies to protect from existing and future threats.

As DFPS continues to adapt to an increasingly dangerous and interconnected network environment, the agency also continues to identify and eliminate risk and employ solutions that support achievement of mission critical goals.

Security of Data

The DFPS network, and the data that it hosts and shares, are protected by tools and software under DFPS control, and the entire network connects to a much larger system with shared resources utilized by all Health and Human Services (HHS) System agencies.

There are currently several security measures in place that provide a high level of protection for DFPS' mobile technology. These include:

- **Encryption technologies** that protect transmission of confidential data in key applications and email,
- **Application software** that encrypts files that are most used by caseworkers, and
- **Special software** that 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, DFPS is studying other protective measures, as described below.

- **Disk encryption** protects information by converting it into unreadable code that cannot be deciphered easily by unauthorized people. This technology is currently being piloted.
- **Two-factor authentication** is a security process in which the user provides two means of identification: a physical token, such as a card, and something typically memorized, such as a security code. This technology is currently being piloted.
- **Data-loss prevention (DLP)** is a set of information security tools that is intended to stop users from sending sensitive or critical information outside of the corporate network. Adoption of DLP, variously called data leak prevention, information-loss prevention, or extrusion prevention, is being driven by significant insider threats and by more rigorous state privacy laws. Many of these laws have stringent data protection or access components. This technology is currently being piloted.

- **File system-level encryption**, often called file or folder encryption, is a form of disk encryption where individual files or directories are encrypted by the file system itself. This is in contrast to full disk encryption where the entire partition or disk, in which the file system resides, is encrypted. This system is currently under study for deployment at DFPS.
- **Advanced Persistent Threat Detection** is technology that DFPS is currently piloting to detect advanced persistent threats (APTs). An APT is an attack in which an intruder, using automated tools, tries to connect and maintain access to a workstation or tablet through apparently legitimate reasons, such as an email appearing to be from a known company like FedEx or the federal Internal Revenue Service. Once access has been achieved, the intruder establishes a back door, which is independent access that is hard to detect, and the intruder stays elusive by mimicking legitimate code. Through this means, the intruder can gain access to information on the computer and have it automatically sent elsewhere, undetected. APT detection technology is currently being piloted at DFPS with very good results.
- **Enterprise Mobility Management** is a system of people, processes, and technology to manage the increasing numbers of mobile devices and wireless networks in DFPS's GoMobile initiative, used by 80 percent of DFPS staff. Since DFPS work involves confidential information that is sent and used outside the security boundaries of the HHS System network, a management system is needed ensure secure management of the devices, information, and applications. This system is currently under preliminary study for a design at DFPS.

DFPS participates with HHS System security management in the use, planning, and implementation of shared network security architecture. Planning is underway to use content-aware DLP tools at both the System and agency levels. DLP's primary purpose is to keep data safe—where it is stored, where it travels, and how it is used. Additionally, these tools will provide expanded capabilities to identify and catalog where sensitive information resides in the agency, and to raise user awareness regarding the proper treatment of sensitive data.

8.5 Agency Goals: Target Populations and Services Descriptions

8.5.1 DFPS Goal 1: Statewide Intake Services

Target Population

Statewide Intake (SWI) is the centralized point of intake for:

- Child abuse and neglect;
- Abuse, neglect, or exploitation of people ages 65 and older and people with disabilities;
- Clients served by the Department of State Health Services in its State Mental Health Hospitals or the Department of Aging and Disability Services its in State Supported Living Centers; and
- Children in licensed child-care facilities or 24-hour care.

Services Description

SWI operates 365 days per year, twenty-four hours per day. SWI receives information via phone, an Internet reporting system, fax, and mailed correspondence. SWI receives an average of 60,930 contacts each month.

SWI's responsibility is to assess information received as it applies to the definitions of possible abuse, neglect, or exploitation for each program served and to prioritize and route the information to the correct program area. When a contact to SWI does not meet statutory definitions of abuse, neglect, or exploitation, SWI often provides helpful information, including referrals to other agencies or organizations that may meet the needs of the situation. SWI generates law enforcement and routes them to the correct law enforcement jurisdiction for all abuse, neglect, and exploitation reports involving children.

In fiscal year 2013, SWI assessed 47.3 percent of all calls taken as intakes or special requests related to abuse, neglect, or exploitation for DFPS. Of the rest of the calls taken, 44.3 percent were assessed as information and referral (I&R) calls related to DFPS work (such as additional information about an open case without an allegation), and 8.4 percent were I&R calls not related to DFPS work (such as providing the number for the Medicare hotline). Of the calls assessed as intakes, 68.5 percent went to Child Protective Services, 29.5 percent went to Adult Protective Services, and 2.0 percent went to Child Care Licensing.

SWI has a Quality Assurance Unit that:

- Reviews complaints;
- Randomly monitors calls for quality; and
- Assists in development of policy, procedure, and best practices.

SWI's Employee Development Unit is responsible for both basic and advanced training for new and tenured staff.

8.5.2 DFPS Goal 2: Child Protective Services

Target Population

The Child Protective Services (CPS) program focuses on Texas families in which children are, or are alleged to be, victims of abuse and/or neglect. According to the Texas State Data Center, 7.1 million children live in Texas.

In FY 2013, the CPS program conducted 160,240 investigations of abuse and/or neglect. CPS confirmed abuse and/or neglect in 40,249, or 25 percent, of reported cases. The most commonly confirmed types of abuse/neglect were physical abuse, physical neglect, and sexual abuse. The 40,249 confirmed cases of abuse or neglect involved 66,398 children.

To protect these children in the future, CPS often contracts for services to help the parents and other family members address the issues that led to the abuse or neglect. The services can include family counseling, crisis intervention, parenting classes, substance abuse treatment and testing, domestic violence intervention, and day care. The following paragraphs describe both certain characteristics of the children served by CPS and also the placement types for these children. Table 8.1 depicts the ethnic and gender representation of the more than 66,000 children in confirmed cases of abuse or neglect during FY 2013.

Table 8.1
Characteristics of Confirmed Victims of Child Abuse, Fiscal Year 2013

Sex	Anglo	African American	Hispanic	Native American	Asian	All Other Population Groups Combined
Female	10,738	5,361	16,177	35	151	1,833
Male	10,183	5,343	14,525	32	151	1,802

Table 8.1: DFPS Databook, FY 2013.

In some cases, children may require substitute care placements outside of their homes. At the end of 2013, DFPS had legal conservatorship for 27,288 children in substitute care. Table 8.2 details the types of placements in which these children were residing.

Table 8.2
Children, Birth through Age 17, in Substitute Care Placements, by Living Arrangement, at the End of Fiscal Year 2013

Type of Living Arrangement[1]	Number of Children	Percentage of Total
Contracted Foster Homes	11,409	41.80%
Kinship Care	10,059	36.90%
DFPS Foster Homes	1,631	6.00%
Residential Treatment Centers	1,476	5.40%
Basic Child care	702	2.60%
Emergency Shelters	538	2.00%
Private Adoptive Homes	497	1.80%
Other Substitute Care	455	1.70%
Other Foster Care	286	1.00%
DFPS Adoptive Homes	225	0.80%
Independent Living	10	0.04%
Total	**27,288**	**100.0%**

Table 8.2: DFPS Data Warehouse, March 2013.

Of the children residing in foster care at the end of FY 2013, 51.5 percent were boys and 48.5 percent were girls. Age groups were represented as follows.

- 25.4 percent were age two or younger.
- 20.1 percent were ages 3 to 5.
- 20.6 percent were ages 6 to 9.
- 15.7 percent were ages 10 to 13.
- 18.1 percent were ages 14 to 17.

Racial and ethnic groups of the children in foster care were represented as follows:

- 42.7 percent Hispanic,

[1] Definitions and other information about each Type of Living Arrangement are available in the Department of Family and Protective Services Databook for 2013.

- 22.2 percent African American,
- 29.2 percent Anglo,
- 0.1 percent Native American,
- 0.2 percent Asian, and
- 5.6 percent all other population groups combined.

The population of children in DFPS conservatorship has decreased over the past three years. This coincided with a decrease in the number of completed investigations over the same years. A lower number of reported intakes to Statewide Intake attributes to the decrease in completed investigations as well.

Services Description

The CPS program focuses on three key outcomes for children: ensuring safety, establishing permanency, and ensuring well-being. To achieve these outcomes, CPS administers six main stages of service.

- **Investigation—**Conducted to determine whether a child has been abused and/or neglected, or to determine whether there is a risk of abuse or neglect.
- **Family-Based Safety Services (FBSS)—**Provided to families while children remain in their own home (Family Preservation Services) or when children who are in CPS legal custody in court-ordered substitute care will be returning to their own home (Reunification Safety Services). FBSS are provided either by CPS staff or contracted providers.
- **Substitute Care Services—**Provided when the child is not safe in the home; these out-of-home care services include foster care and adoption services.
- **Family Reunification Services—**Provided when the court determines that a child should return home after residing in foster care.
- **Adoption—**Provided when it is not possible for a child to return home, and the court has terminated the parents' rights and made the child available for adoption.
- **Preparation for Adult Living—**Provided to youth 16 years of age or older to aid with the transition from foster care into adulthood.

8.5.3 DFPS Goal 3: Prevention Programs

Target Population

Prevention and Early Intervention (PEI) target populations include children at-risk for experiencing child maltreatment and juvenile delinquency and those in other at-risk situations. Families without prior involvement with Child Protective Services (CPS) are a primary focus of PEI. Contracted prevention services are available in each of

the state's 254 counties, though not all services are available in all counties. The PEI section of the DFPS Web site (www.dfps.state.tx.us) provides information about the availability of PEI programs in each of the state's 254 counties. This website is updated regularly to provide Texans with timely information on prevention and early intervention services. PEI programs are administered through contracts with local community agencies or organizations. Programs are discussed in the following Service Description section.

Services Description

The PEI Division manages the statewide prevention services contracts through the following programs to prevent child maltreatment and juvenile delinquency. The division focuses on contracting for quality services and is charged with identifying and measuring meaningful outcomes for contracted services. Services prevent child maltreatment and juvenile delinquency by reducing risk factors and increasing protective factors to increase resiliency of Texas children, youth and families. Below are brief descriptions of each Prevention and Early Intervention program.

- **Community-Based Child Abuse Prevention Program—**This program seeks to increase community awareness of existing prevention services and to strengthen community and parental involvement in child-abuse prevention efforts. It funds several different programs.
  - The Family Support Program focuses on counties with a higher-than-state-average rate of child abuse and neglect, with special focus on rural counties. The program includes home visiting, case management, crisis intervention, and an evidence-based parent education component. This program targets families with children from birth through age five, as data reviewed indicates these children are statistically at greater risk for abuse and neglect.
  - The Respite/Parent Education Program provides emergency day and overnight respite to children of at-risk families in Bexar and El Paso Counties. In addition, parent education is provided to mitigate the risk of child abuse and neglect.
  - The Basic Parent Education program focuses on providing parent skills training to at-risk families in Bexar County.

  In FY 2013, the combined programs served 990 families.
- **Community Youth Development (CYD)—**The CYD program provides community-based juvenile delinquency prevention services in fifteen urban zip codes of the state that are known to have a high incidence of juvenile crime. This program serves children ages 6 through 17, with a focus on youth ages 10 through 17. Committees made up of local community members and youth representatives assess community strengths and needs, identify funding priorities, and review proposals submitted by prospective service providers for funding through local procurement by the primary contractor. Examples of CYD Program services include youth leadership development, life skills classes,

character education, conflict resolution, enrichment, tutoring, mentoring, and recreation. In FY 2013, the CYD Program served 16,767 youth.

- **Services to At-Risk Youth (STAR)—**The STAR program currently provides services to all 254 Texas counties. STAR services are provided to several populations:
  - Youth younger than age 18 who are runaways, truants, and/or living in family conflict, or at risk of other abuse, and who did not meet the criteria for CPS;
  - Youth younger than age 10 who have allegedly been involved in or committed delinquent offenses; and
  - Youth ages 10 to 16 who have allegedly committed misdemeanor or state jail felony offenses but have not been adjudicated delinquent by a court.

  Services must include family crisis-intervention counseling, short-term emergency residential care, individual and family counseling, youth and parent skills groups, and universal child abuse and neglect prevention activities. The STAR program served 23,677 families in FY 2013. Over two-thirds (71.9 percent) were referred for reasons of family conflict. The remaining youth were referred to STAR because they were truant (13.9 percent), had committed offenses (13.3 percent), or were runaways (0.9 percent).
- **Texas Families: Together and Safe (TFTS)—**TFTS is a DFPS program of family support grants. Evidence-based family support services are provided through community-based programs. The goal of the TFTS program is to strengthen families and ultimately prevent child abuse and neglect. In particular, TFTS concentrates on developing parental and familial understanding, strengthening parental resiliency, increasing knowledge of parenting and child development, increasing social connections, and providing concrete support in times of need. TFTS providers work with other community-based organizations to build access to an array of coordinated, family-centered resources that are tailored to best meet the needs of the community. During FY 2013, 1,736 families received TFTS services.
- **Community Based Family Services—**This program serves families who were investigated by CPS but whose allegations were unsubstantiated. The program provides evidence-based services at the community level to prevent child abuse and neglect. Services include home visitation, case management, and additional social services to provide a safe and stable home environment. In FY 2013, 287 families were served in Bexar and Guadalupe counties
- **Statewide Youth Services Network—**The Statewide Youth Services Network is available in all DFPS regions. The program provides evidence-based juvenile delinquency prevention services to improve conditions that typically result in negative outcomes for children and youth. The program is open to children ages 6 through 17 with a focus on youth ages 10 through 17. During FY 2013, this program served 4,384 youth.

- **Healthy Outcomes through Prevention and Early Support Program—**This program is a new effort for FY 2014 which will contract with community-based organizations to provide child abuse and neglect prevention services that target families with children from birth through age five. Contracts will be awarded starting in FY 2015 in targeted counties. The contracts will include a home-visiting program component and other services that will meet the needs of the target county and should include collaborations between child welfare, early childhood education, and other child and family services.
- **Help through Intervention and Prevention Program—**This program is a new effort for FY 2014. It provides voluntary services to families to increase protective factors and prevent child abuse. The program provides an extensive family assessment, home visiting programs that include parent education and basic needs support to targeted families. Eligible families are:
  - Families who have previously had their parental rights terminated due to child abuse and neglect in 2008 or later and who currently have a newborn child,
  - Families who have previously had a child die with the cause identified as child abuse or neglect in 2008 or later and who have a newborn child, or
  - Young women who are currently in foster care who are pregnant or who have given birth in the last four months.

  Contracts have begun in FY 2014. As of April 1, 2014, one contract is in place, and provider enrollment is currently open.
- **Texas Youth and Runaway Hotlines—**These hotlines serve Texas youth and families. Hotline staff and volunteers work closely with social service agencies and juvenile delinquency prevention programs to provide 24-hour crisis intervention and telephone counseling. This includes conference calls to parents and shelters, a confidential message relay service between runaways and parents, paging services for callers in need of immediate assistance from program staff after regular office hours, and information and referrals to callers in need of food, shelter, and transportation to their homes. Callers with a broader range of youth-related concerns can talk to a trained volunteer who provides referral information, crisis intervention, and/or telephone counseling to the callers. Collectively, the two hotlines attended to 7,462 calls during FY 2013. The database for both hotlines contains approximately 2,300 listings of state and local resources.

8.5.4 DFPS Goal 4: Adult Protective Services

Target Populations

The Adult Protective Services (APS) program serves people who are 65 and older and people with disabilities who are experiencing or who are at risk of abuse, neglect, and/or exploitation. In 2013, there were nearly 3 million Texans ages 65 and older and almost 1.7 million Texans with a disability who were between ages 18

and 64. APS investigates allegations of abuse, neglect, and/or exploitation for persons in two settings:

- Their own homes; and
- State-operated and/or state-contracted settings that serve adults and children with mental illness, intellectual disabilities, and/or developmental disabilities.

In-Home Investigations and Services

The APS In-Home Investigations and Services (In-Home program) protects people ages 65 and older and people who have disabilities and reside in the community. APS does this by investigating reports of abuse, neglect, and financial exploitation and by providing or arranging for services to alleviate or prevent further maltreatment. APS works with vulnerable adults who reside in their own homes or in unregulated “room-and-board” homes. APS also investigates allegations of financial exploitation of vulnerable adults living in nursing homes who may be financially exploited by someone outside the facility.

In FY 2013, the APS In-Home program completed 69,383 investigations and validated 48,392 (69.7 percent) of those investigations. Of the 48,392 victims in validated FY 2013 investigations, 29,773 (61.5 percent) were people age 65 or older, and 18,619 (38.5 percent) were people ages 18 to 64 who have a disability. Almost 60 percent of the victims in validated In-Home program investigations were women.

The most common type of maltreatment validated was physical neglect, which was found in 67.3 percent of the cases validated. Ethnic groups of victims in validated cases were represented as follows:

- 51.8 percent Anglo,
- 20.6 percent African American,
- 24.0 percent Hispanic,
- 0.2 percent Native American,
- 0.7 percent Asian, and
- 2.6 percent from all other population groups combined.

The number of completed APS In-Home program investigations is projected to increase steadily during the strategic planning period of 2015–2019. One major reason for the increase is the growth in the number of "baby boomers" who are reaching age 65.

Facility Investigations

The APS Facility Investigations program investigates allegations of abuse, neglect, and exploitation of adults and children receiving mental health, intellectual disability, and developmental disability services in state-operated or state-contracted settings.

In FY 2013, 10,818 facility investigations led to 1,373 confirmed cases. Neglect was confirmed in 63 percent of all confirmed investigations, followed by physical abuse, the second most common type, found in 19.8 percent of confirmed cases. State Supported Living Centers (SSLCs) were the most common setting for facility investigations, accounting for 31.5 percent of completed investigations.

Services Description

APS operates two programs: In-Home Investigations and Services, and Facility Investigations.

In-Home Investigations and Services

In cases validated by the In-Home program, if needed, APS caseworkers provide or arrange for protective services, including short-term assistance with shelter, food, medication, health services, heavy cleaning, transportation, minor home repair, and financial assistance for rent and utilities. The In-Home program completed 69,383 investigations in FY 2013, with 48,392, or 69.7 percent, of those investigations resulting in validated allegations of abuse, neglect, or financial exploitation.

Facility Investigations

The Facility Investigations program investigates reports of abuse, neglect, and exploitation of adults and children receiving mental health, intellectual disability, and developmental disability services in:

- State-operated facilities:
  - State-operated psychiatric hospitals,
  - SSLCs, and
  - The Rio Grande State Center; and
- State-contracted settings:
  - Community centers,
  - Home and Community-based Services programs (HCS),
  - Texas Home Living Waiver Program, and
  - Privately-operated intermediate care facilities for individuals with intellectual disabilities (ICFs-IID).

In FY 2013, APS completed 10,818 investigations in facility settings, of which 3,411 were performed in SSLCs, 3,114 in HCS settings, 2,531 in state-operated psychiatric hospitals, 1,066 in privately-operated ICFs-IID, 543 in community centers, and 153 in the Rio Grande State Center.

8.5.5 DFPS Goal 5: Child Care Regulation

Target Population

There are two main target populations for the Child Care Licensing (CCL) program area:

- Children attending day care for less than 24 hours per day, and
- Children residing in residential child care facilities.

These children's caregivers—parents, guardians, and/or service providers—are also target populations.

In FY 2013, the capacity of regulated child care operations in Texas was 1,085,366 children. The capacity of residential child care providers was 40,843 children.

Services Description

The CCL program safeguards the basic health, safety, and well-being of Texas children by developing and enforcing minimum standards for child care facilities and child-placing agencies. The program regulates child day care homes and centers, before- and after-school programs, school-age programs, employer-based day care facilities, and day care programs in temporary shelters such as family violence shelters and homeless shelters where care is provided to a child while the child's parent is not present. The CCL program also regulates child-placing agencies and 24-hour residential child care facilities such as general residential operations providing emergency shelter services and residential treatment centers.

CCL is responsible for:

- Issuing licenses, registrations, certificates, or listings, depending on the type of care being provided;
- Developing minimum standards and administrative rules to promote the health, safety, and well-being of children in out-of-home care;
- Inspecting child-care operations and enforcing regulatory requirements to ensure the operations maintain compliance with minimum standards;
- Conducting additional inspections of a random sample of agency foster homes;
- Conducting annual conferences for enforcement teams for child-placing agencies and residential treatment centers to thoroughly review operations;
- Investigating allegations of:
  - Abuse and neglect,
  - Violations of minimum standards or law, and
  - Illegally operating child care providers;
- Imposing corrective and adverse actions when necessary;

- Conducting criminal background checks and DFPS Central Registry checks on all adult staff or caregivers, and other adults and youth ages 14 through 17 who will be in regular or frequent contact with children in child-care operations; and
- Educating the general public about choosing regulated child-care and informing them of the child-care options in Texas through media campaigns and by maintaining an online database of child-care providers, including information regarding each operation's compliance history.

Licensing employees also provide information, advice, training, and consultation to child-care operations to facilitate compliance with minimum standards and achieve program excellence. Technical assistance is often provided in the areas of:

- Background checks and record-keeping;
- Building and equipment maintenance;
- Child health, safety, and nutrition; and
- Age-appropriate activities, supervision, and discipline.

The Technical Assistance Library, located on the agency's public website, provides additional technical assistance to providers, parents, and others.

The following paragraphs focus on the demand for services within the different facility types.

Day Care Licensing

In FY 2013, approximately 5.5 million children younger than age 14 lived in Texas. Many of these children were in the care of a day care provider on a regular basis for a substantial part of the day. In FY 2013, CCL was responsible for regulating 9,533 licensed child care centers, 1,756 licensed child care homes, 5,266 registered family homes, and 5,411 listed family homes, for a total, combined capacity to serve more than one million Texas children. In FY 2013, CCL issued a combined 3,871 new licenses, registrations, and listings, and it conducted 36,687 inspection visits in regulated child day care facilities. Table 8.3 lists the total number of licensing inspections performed in regulated child day care facilities.

Table 8.3
Number of Inspection Visits in Regulated Child Care Facilities, Fiscal Year 2013

Day Care Facilities	Total Number of Facilities	Number of Inspection Visits
Licensed Child Care Centers (includes Child Care Programs, Before/After School Programs, and School-Age Programs)	9,533	25,149
Licensed Child Care Homes	1,756	3,790
Registered Family Homes	5,266	5,702
Listed Family Homes	5,411	2,037
Temporary Shelter Programs	8	8
Employer-Based Child Care	6	1
Total	**21,980**	**36,687**[2]

Table 8.3: DFPS Databook, FY 2013.

Residential Licensing (24-Hour Care)

The CCL program licenses and regulates 24-hour residential child care facilities including general residential operations, residential treatment centers (which are a subset of general residential operations), and child-placing agencies. In FY 2013, Texas' residential child care facilities had a combined capacity to serve more than 40,000 children. In FY 2013, CCL issued 43 permits for new residential child care facilities and performed 4,684 inspection visits. Table 8.4 lists the total number of licensing inspections conducted in regulated residential child care facilities in FY 2013.

[2] Beginning in FY 2012, the Legislative Budget Board (LBB) Performance Measure definition of inspections does not include inspections completed as part of an investigation.

Table 8.4
Number of Inspection Visits in Regulated Residential Child Care Facilities, Fiscal Year 2013

Residential Child Care Facilities	Total Number of Facilities	Number of Inspection Visits
General Residential Operations (not including Residential Treatment Centers)	161	523
Residential Treatment Centers	74	485
Child Placing Agencies (includes 153 Branch Offices)	370	1,268
Child-Placing Agency Foster and Foster Group Homes	7,581	2,046
CPS Adoptive, Foster and Foster Group Homes	2,096	343
Independent Foster Homes and Group Homes	4	19
Total	**10,286**	**4,684**[3]

Table 8.4: DFPS Databook, FY 2013.

[3] Beginning in FY 2012, the Legislative Budget Board (LBB) Performance Measure definition of inspections does not include inspections completed as part of an investigation.

Chapter 9

Department of State Health Services Strategic Plan 2015–2019

9.1 Overview

The Department of State Health Services (DSHS) is responsible for oversight and implementation of public health and behavioral health services in Texas. With an annual budget of $3 billion and a workforce of approximately 12,000 employees, DSHS is the fourth largest state agency in Texas.

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. DSHS accomplishes this mission in partnership with numerous academic, research, and health and human services stakeholders within Texas, across the country, and along the United States/Mexico border. The Health and Human Service (HHS) System partners, as listed, perform important roles in working collaboratively to address existing and future issues faced by the agency:

- HHS System agencies,
- DSHS regional offices and hospitals,
- Local mental health authorities,
- Federally qualified health centers,
- Local health departments, and
- Contracted community service providers.

The remainder of this chapter is arranged as follows:

- Mission,
- External Challenges and Opportunities,
- Internal Challenges and Opportunities, and
- Agency Goals: Target Populations and Services Descriptions.

9.2 Mission

The mission of DSHS is to improve health and well-being in Texas.

9.3 External Challenges and Opportunities

9.3.1 Improving Health Through Prevention

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

- Emphasize health promotion, disease prevention, early intervention, and primary care, in a quality-oriented, electronically enabled, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Improve access to effective services across systems for behavioral health, including prevention, treatment, and recovery services, and integrate physical and behavioral health services.
- Improve access to preventive health care and family planning services for women.
- Ensure all programs and initiatives recognize and address health disparities and disproportionality to improve outcomes.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Discussion

The contribution of public health efforts to society is measured in the dramatic improvements in well-being and life expectancy during the 20th 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 and infectious diseases are the leading causes of death in the U.S. and Texas. Mental

illness and substance use disorders also contribute to health issues and affect people's ability to participate in health-promoting behaviors.

Chronic Diseases

Chronic diseases impact thousands of Texans each year. Many of these conditions are exacerbated by behavioral risk factors such as tobacco use, consumption of alcohol and other drugs, obesity, physical inactivity, and poor nutrition. See Chapter 3, Table 3.1 and related text for information relating to the ten leading causes of death in Texas in 2011.

Alzheimer's Disease

Alzheimer's disease (AD) affects an estimated 5.2 million Americans, and 340,000 of those individuals are Texans. Texas ranks third in the number of AD cases and second in the number of AD deaths. AD is the sixth leading cause of death in the U.S. and has an economic burden that exceeds $216.4 billion annually. Today, a person's health can easily outlast his or her cognitive and mental abilities.

Asthma

In Texas, approximately 1.4 million adults and 557,000 children have asthma, a chronic respiratory disease that makes it difficult to breathe. Asthma is one of the most common childhood diseases and one of the most frequent reasons for emergency room visits and missed days of school for children. Uncontrolled asthma symptoms may require emergency care or hospitalization and may result in death if untreated.

Cancer

Cancer, the second leading cause of death in Texas, represents more than 100 distinct diseases characterized by the uncontrolled growth and spread of abnormal cells in the body. In 2013, it is estimated that more than 117,371 Texans were newly diagnosed with cancer, and about 41,362 died from the disease. Behaviors contributing to the cancer rate include tobacco use, poor nutrition, physical inactivity, and obesity.

Cardiovascular Disease

Cardiovascular disease (CVD) and stroke are the number one and number four causes of death in Texas; however, these chronic diseases are largely preventable through the reduction of modifiable risk factors. The prevalence of CVD, as well as CVD and stroke-related morbidity and mortality rates, can be reduced by increased physical activity; good nutrition; tobacco cessation; control of high blood pressure, high cholesterol, and diabetes; and maintaining a healthy weight.

Chronic Kidney Disease

Chronic kidney disease (CKD) affects 15 percent of the adult population. CKD is a slow progressive loss of kidney function over several years that often goes undetected and undiagnosed until the disease is well advanced and kidney failure is imminent. As kidney failure advances, dangerous levels of waste and fluid can build up rapidly in the body, leading to CVD, hypertension, and other comorbid conditions. Risk factors include diabetes, hypertension, CVD, obesity, family history of kidney problems, certain autoimmune disorders and medications, and reflux nephropathy.

Diabetes

In 2011, diabetes was the seventh leading cause of death in Texas. The prevalence of diabetes increased by 56.6 percent between 2000 and 2010. Overall, adult African Americans (16.5 percent) had significantly higher diabetes prevalence compared to Hispanics (11 percent) and Anglos (8.1 percent). In adults 65 years and older, both African Americans and Hispanics have significantly higher prevalence (38 percent and 32 percent respectively) compared to Anglos (19.2 percent). In 2010, an estimated 9.7 percent of adult Texans 18 years or older (1.8 million) reported they had been diagnosed with diabetes. About one in twenty adult Texans (1 million) had been diagnosed with prediabetes, a condition in which individuals have blood sugar levels higher than normal but not high enough to be classified as diabetes. People with prediabetes have an increased risk of developing type 2 diabetes, heart disease, and stroke. Obesity is a leading risk factor for type 2 diabetes. Diabetes can lead to disabling health conditions, including heart disease, stroke, kidney failure, leg and foot amputations, and blindness.[1]

Behavioral Risk Factors

Behavioral risk factors such as tobacco use, obesity, and consumption of alcohol and other drugs can increase an individual's risk of developing a disease or disability. DSHS prevention programs seek to change these behavior patterns in order to reduce the incidence of disease and promote healthy lifestyles across the lifespan.

Tobacco Use

Tobacco use is the single largest cause of preventable disease and premature death 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. Tobacco products are associated with the deaths of more than 400,000 people in the U.S. every year. In Texas, 24,200 adults die annually from smoking-related causes. Additionally, for every person who dies from a tobacco-related cause, an additional 20 suffer from tobacco-related diseases.

[1] DSHS Office of Surveillance, Evaluation, and Research. "The Burden of Diabetes in Texas," 2013. (www.dshs.state.tx.us/diabetes/PDF/data/diabetesburdenreport2013.pdf)

Obesity

Obesity is a major driver of poor health in Texas, as it is a risk factor for chronic diseases, such as diabetes, heart disease, stroke, arthritis, and certain types of cancer. In 2012, two out of three adult Texans were either overweight or obese, with rates higher among African Americans (71.2 percent) and Hispanics (71.1 percent) than among Anglos (61.7 percent). The Texas state demographer projects that, if current trends continue at the pace of the last ten years, then by 2030, 36.7 percent of Texas adults will be obese (body mass index (BMI) over 30), 36.4 percent will be overweight (BMI 25-30) and, only 26.9 percent will be at normal weight (BMI less than 25).

Substance Abuse

According to the Texas Behavioral Risk Factor Surveillance System (BRFSS), the percentage of Texas adults reporting they had consumed alcohol in the past month decreased from 49.9 percent in 2010 to 49.3 percent in 2012. In 2012, 16.2 percent reported past-month binge drinking; and 6.1 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 and ethnicity was 8.2 percent for Anglos, 4.6 percent for Hispanics, and 3.3 percent for African Americans.

Among the youth population, the Texas School Survey of Substance Use found a decrease in reported past-month binge drinking for all ethnic groups from 2010 to 2012: 23.7 percent to 20.3 percent for Hispanic students, 19.2 percent to 17.4 percent for Anglo students, and 13.0 percent to 10.8 percent for African-American students. In 2012, the percentage of past-month illegal drug use was 14.0 percent of Hispanic students, 13.2 percent of African-American students, and 11.8 percent of Anglo students.

Infectious Disease

Bacteria, viruses, or other microorganisms cause infectious diseases. Although some infectious diseases have been mostly eradicated in the U.S., new infectious diseases are emerging and ones thought to be under control are re-emerging. Continued efforts are needed to prevent and treat diseases that remain prevalent, such as human immunodeficiency virus (HIV), tuberculosis (TB), and vaccine preventable diseases.

Human Immunodeficiency Virus

From 2004 to 2012, the number of persons living with HIV in Texas increased about 35 percent. At of the end of this period, 72,932 people are known to be living with HIV in Texas. The increase in people living with HIV reflects continued survival due

to better treatment, not an increase in new diagnoses. The number of new infections has been level at about 4,200 per year over the last five years.

Tuberculosis

In 2012, there were 1,233 cases of active TB reported in Texas. Foreign-born persons account for a significant percentage of TB morbidity, representing 39 percent of cases reported in 1999 and increasing to 54 percent in 2012. In 2012, Texas border counties had a TB rate of 9.0 cases per 100,000 residents, while non-border counties had a rate of 4.2 per 100,000. The total state rate was 4.7 per 100,000 residents, which exceeds the national rate of 3.2 per 100,000 population.

Vaccine-Preventable Diseases

Vaccines are recognized as one of the top ten public health successes of the 20th century. Diseases like measles, mumps, rubella, diphtheria, and polio were once common. Today, vaccine-preventable diseases are relatively rare across the U.S. due to increased awareness of vaccines and their benefits.

Through the use of vaccines, public health efforts have been able to decrease the incidence of several diseases. For several years, Texas has not had any cases of rubella, polio, or diphtheria. The incidences of hepatitis A, acute hepatitis B, and varicella (chicken pox) have decreased steadily and are now at historic lows. There were recent outbreaks of pertussis and mumps in Texas, but extensive control efforts have successfully interrupted transmission of both diseases. Measles has been declared eliminated in the Americas, but measles is endemic in much of the rest of the world, and international travel leaves Texans at risk for measles exposure. In 2013, 27 cases of measles were identified in Texas. Of these, 26 were associated with foreign travel or exposure to an individual who had traveled abroad and 21 were within a church community with low rates of vaccination.

Mental Illness

Mental illness is a leading cause of disability in the U.S., Canada, and Western Europe. Two large national surveys conducted in the 1980's and 1990's serve as the basis for prevalence estimates for the adult population.[2] It is estimated that 19 percent of the adult U.S. population have a mental disorder during the course of a year. In Texas, the 2013 estimated number of adults with serious and persistent mental illness was 499,389.

People with severe mental illness die, on average, 25 years earlier than the general population.[3] Premature mortality among this population is predominately due to

[2] U.S. Department of Health and Human Services. "Mental Health: A Report of the Surgeon General," 1999. (http://www.surgeongeneral.gov/library/mentalhealth/home.html).
[3] National Association of State Mental Health Program Directors. "Morbidity and Mortality in People with Serious Mental Illness," 2006.

preventable diseases, such as diabetes, hypertension, and heart disease. Some of the greatest risk factors leading to premature death are smoking, obesity, substance abuse, and inadequate access to medical care.

Approximately 20 percent of children and adolescents have some type of mental disorder. Federal regulations also define a sub-population of children and adolescents with more serious functional limitations, known as serious emotional disturbance (SED). Children and adolescents with SED comprise approximately 5-9 percent of children ages 9–17.[4]

Infant and Maternal Mortality

Despite major advances in medical care, poor birth outcomes continue to be a problem in the U.S. and Texas. The number of deaths of infants less than one year of age per 1,000 live births was 5.7 in Texas in 2011. The leading causes of infant mortality are birth defects, disorders related to preterm birth and low birth weight, and sudden infant death syndrome. Risk factors include no prenatal care, poor preconception health, tobacco use, and unsafe sleep environments.

Babies born preterm (before 36 completed weeks of gestation) have a greater risk of dying within their first year of life. The Texas preterm birth rate has consistently been higher than the national average over the past ten years. The percent of infants born preterm in recent years ranged from 12.6 percent in 2000 to 13.7 percent in 2005. In 2011, 12.8 percent of Texas births were preterm, compared to 11.7 percent for the U.S.

The World Health Organization uses maternal mortality as a measure of health and well-being of women across the globe; however, the mortality rate may not accurately describe the magnitude of pregnancy-related deaths. Researchers at the national and state levels have found that maternal deaths are often underreported, particularly deaths of women occurring more than 42 days after the end of a pregnancy. Research has shown that information recorded on death certificates and other vital records can be inaccurate and does not provide enough information on the circumstances surrounding a birth or death.

Even given the reporting problems, the maternal mortality rate in the U.S. has nearly doubled in a decade and is higher than in 40 other industrialized countries. In Texas, the rate increased from 13.7 deaths per 100,000 live births in 2007, to 24.4 deaths per 100,000 live births in 2011. Experts do not yet know what has caused the increase in deaths. Potential explanations include the fact more women today are giving birth in their 30s and 40s, when risks of complications during pregnancy and childbirth significantly increase. Additionally, almost 25 percent of women of childbearing age are obese and thus at higher risk for conditions such as diabetes and high blood pressure.

[4] U.S. Department of Health and Human Services. "Mental Health: A Report of the Surgeon General," 1999. (http://www.surgeongeneral.gov/library/mentalhealth/home.html).

Planned Actions

Tobacco Prevention and Control

The Tobacco Prevention and Control Program activities are guided by goals and objectives developed through a statewide strategic planning process that includes regional and local stakeholders and partners. Program goals include preventing initiation of tobacco use, increasing cessation of tobacco use by youth and adults, eliminating exposure to secondhand smoke in public places, and eliminating disparities among diverse and special populations. Specific activities include:

- Funding and developing local coalitions to address local tobacco issues;
- Funding Quitline, a statewide telephone counseling initiative for tobacco cessation;
- Utilizing media to support program goals;
- Changing tobacco norms through policy and environmental changes;
- Implementing best practices and evidence-based approaches at the local and state levels; and
- Utilizing appropriate surveillance and evaluation methods to measure program outcomes.

Obesity Prevention

The Community and Worksite Wellness Program supports and promotes projects that focus on the six evidence-based target areas for reducing obesity identified by the Centers for Disease Control and Prevention (CDC). These target areas include increasing physical activity; increasing consumption of fruits and vegetables; decreasing consumption of sugar-sweetened beverages; reducing consumption of high-calorie foods; increasing breastfeeding initiation, duration, and exclusivity; and decreasing television viewing. The program targets large segments of the population by promoting strategies to reduce environmental barriers to healthy living and encourage policies that facilitate healthy choices.

Fiscal year 2014 is the program's first year of funding under a new five-year CDC combined chronic disease prevention grant. With CDC funds, the program will continue to support:

- Implementation of policies and practices in early childcare education settings that support improved nutrition and increased physical activity;
- Implementation of the Strategic Plan for the Prevention of Obesity in Texas;
- Coordination of resources and technical assistance to support implementation of wellness and health promotion policies and activities in worksites statewide;

- Online professional training modules for physical activity, sustainable agriculture, and breastfeeding; and
- Coordination of subject matter expertise and participation and coordination with state partnerships, councils, and groups to enhance statewide efforts toward obesity prevention.

Substance Abuse Prevention

DSHS funds one training contract and approximately 133 school- and community-based programs statewide to prevent the use and consequences of alcohol, tobacco, and other drugs (ATOD) among Texas youth and families. In fiscal year 2013, these programs provided evidence-based curricula and prevention strategies in 484 independent school districts. The primary population served is youth, ages 6–18, and the secondary population includes the parents and guardians of these youth. Specific services target youth ages 11–17 and young adults ages 18–21 who are experiencing early warning signs of substance abuse and other related behavioral problems. In addition to these direct services, 11 regional prevention resource centers (PRCs) collaborate with the centralized training service entity in meeting staff competency requirements. The PRCs also are the hubs of data collection within the regions. Additionally, 44 community coalitions, located throughout the state, mobilize community stakeholders to address ATOD policy and environmental change, such as city-wide tobacco ordinances, in their local communities.

HIV Prevention and Control

The number of Texans living with HIV rises each year. The growth in living cases is explained by the consistently low number of annual deaths since 1997 due to effective treatment that allows people with HIV to live longer. One recent study shows that people on effective treatment medications have life expectancies that are similar to those of people without HIV.[5]

The importance of maintaining programs and access to medical care and adherence services continues as a high priority. Supportive services such as case management, medical transportation, and mental health and substance abuse treatment play key roles in keeping persons with HIV in care and treatment. DSHS will continue to work with communities across Texas to improve the productivity of HIV testing programs by assuring that targeted testing programs focus on groups at highest risk, that routine testing in health settings is established in communities of high morbidity, and that public health partner notification programs operate effectively.

[5] Samji H, Cescon A, Hogg RS, Modur SP, Althoff KN, et al. (2013) Closing the Gap: Increases in Life Expectancy among Treated HIV-Positive Individuals in the United States and Canada. PLoS ONE 8(12): e81355. doi:10.1371/journal.pone.0081355

Goals for HIV prevention and control are:

- Promoting integration of HIV, sexually transmitted diseases (STDs), and viral hepatitis testing or treatment into primary care settings, drug treatment programs, and other health and human services settings;
- Examining how electronic health records and exchanges can simplify and improve disease and program reporting;
- Enhancing the capacity of community partners to use and share models of linkage and engagement in care for persons with HIV that allow more widespread use of these approaches across the state; and
- Promoting new approaches to STDs and HIV diagnosis and treatment delivery that make the most of technology.

TB Prevention and Control

The TB Prevention and Control Program supports a spectrum of disease prevention and control activities to manage persons diagnosed with TB effectively, including persons suspected of having TB and persons with latent TB infection. Services include screening and testing; clinical assessment, diagnosis and treatment; medical case management; and expert medical and nursing consultation. The goals of the DSHS TB prevention and control programs are:

- Developing and maintaining an active disease surveillance mechanism to assure all persons meeting the case definition of suspected or active TB disease are promptly identified and reported to DSHS;
- Developing and maintaining standard processes to guide outbreak responses and assure all persons exposed to TB are promptly identified and screened and, where appropriate, receive treatment to prevent disease transmission;
- Developing and maintaining a robust case management data application that captures all vital case management data to assess statewide performance in treating TB, including contact investigation activities;
- Promoting and expanding the use of innovative technologies to rapidly identify TB infection and disease for prompt diagnosis and treatment;
- Promoting effective treatment modalities that increase compliance among persons diagnosed with latent TB infection; and
- Promoting targeted interventions to populations most at risk for developing TB.

The Texas Center for Infectious Disease (TCID) provides inpatient services for patients with TB, Hansen's disease, and other related infectious diseases requiring long lengths of stay to complete treatment. For surgical services, intensive care, sophisticated diagnostics, advanced therapeutics, and emergency care, TCID contracts with the University of Texas Health Science Center at Tyler, the University of Texas Health Science Center at San Antonio, and other San Antonio-area providers. The facility provides outpatient services to treat patients with TB and Hansen's disease, as well as complications and co-morbidities affecting treatment of

those diseases. TCID has the capability to respond to acts of bioterrorism and to provide first-line responders with expertise in communicable disease treatment.

Immunizations

The overall immunization coverage levels for Texas children measured in the National Immunization Survey for 2012 was 64.8 percent. In 2012, the methodology for the National Immunization Survey changed to include a significant increase in the number of interviews conducted via cell phones, which now closely resembles the U.S. population with respect to telephone service. Due to the change in the methodology, CDC has encouraged states to use the 2012 coverage levels as the baseline against which subsequent trends in coverage are evaluated. Coverage levels for adults continue to be a challenge. Unlike childhood vaccines that are recommended at specific intervals and ages, the recommendations for adult vaccines vary over the lifespan. DSHS will continue to support efforts to increase adult immunization rates.

DSHS will continue to support efforts to increase child and adult immunization rates. To increase vaccination coverage rates, DSHS:

- Promotes giving vaccines in the medical home;
- Promotes the use of ImmTrac, the statewide immunization registry;
- Educates providers and the public on the importance of vaccinations; and
- Implements reminder/recall systems.

Increase Public Understanding of Mental Illness

DSHS is implementing a public awareness campaign designed to increase awareness of the warning signs of mental health and substance use disorders among teen and young adults, to demystify mental illness by making it familiar and educating people that it is treatable, and to equip teen support systems to recognize warning signs and take action. The campaign includes online, television, and radio advertising, as well as a website with resources and other information. Additionally, DSHS is holding facilitated community conversations around mental health in the summer of 2014.

DSHS will also provide training for educators on mental health first aid, which is a curriculum that includes information on signs of addictions and mental illness, the impact of these disorders, how to access a situation and act, and local resources for assistance. This training effort is aimed at assisting school personnel address behavioral health issues in school settings.

Healthy Texas Babies

The Healthy Texas Babies (HTB) initiative helps communities decrease infant mortality and reduce disparities in birth outcomes using evidence-based

interventions. The initiative, led by DSHS in collaboration with the Health and Human Services Commission and the Texas Chapter of the March of Dimes, involves a variety of stakeholders, including community members, healthcare providers, and insurance companies. Programmatic components of the initiative include the following efforts.

- **Professional Education—**In-person and online continuing education for providers covers topics relevant to maternal and infant health. Professional education assures that providers are providing care based on up-to-date standards of practice and the latest research. Professional education also addresses issues of cultural competence and communication that can significantly impact the quality of care received.
- **Public Awareness Campaign—**The *Someday Starts Now* website, materials, and outreach activities enhance public awareness of the impact of preconception health on birth outcomes and infant health. The site also features tools intended to enhance patient health literacy and open the lines of communication between providers and patients about the role of preconception planning in the assurance of healthy birth outcomes.
- **Support of the Texas Collaborative for Healthy Mothers and Babies—**Having the advice and input of a professional network of leaders in maternal infant health contributes to the long-term sustainability of the effort. The iterative feedback of stakeholders most impacted by infant mortality and preterm birth, including family advocates, local health departments, clinicians, and insurance companies assures that the voice of the organization is diverse and informed by varied experiences of the impact of infant mortality. More information about the collaborative is available in Chapter 4 of this document, in Section 4.4.5.
- **Preconception Peer Educator Training—**African-American women and their babies are impacted by poor birth outcomes at disproportionately higher rates than Anglo and Hispanic women and babies. African-American college students are well-poised to deliver preconception health messages and influence behavior change among their peers and in their communities to impact these outcomes. The Preconception Peer Educator Training Program was developed at the national level by the Office of Minority Health Resource Center and is implemented at dozens of historically black colleges and universities nationally. This program trains young men and women on the importance of preconception health, life planning, and the impact of social determinants of health on their well-being. Currently there are active programs on the campuses of Texas Southern University, Prairie View A&M University, and Wiley College, supported by the HTB initiative.
- **Local Community Coalitions—**DSHS funded 11 local coalitions implementing evidence-based interventions around the state. Local coalitions have the potential to make significant and sustainable differences in infant mortality rates in their communities if the coalitions are equipped with updated, local data and are able to track outcomes.

Breastfeeding Promotion

Breastfeeding benefits the health, growth, immunity, and development of infants. Infants who are not exclusively breastfed are at increased risk for acute infections, hospitalization, sudden infant death syndrome, and necrotizing enterocolitis (a debilitating and often fatal intestinal condition of the preterm infant), as well as long-term risk for obesity, type 1 and type 2 diabetes, asthma, childhood leukemia, atopic dermatitis, and other adverse outcomes. Mothers who do not breastfeed are at increased lifetime risk for type 2 diabetes, breast and ovarian cancers, cardiovascular disease, metabolic syndrome, and rheumatoid arthritis. Not breastfeeding or early weaning is also associated with an increased risk of maternal postpartum depression. The American Academy of Pediatrics recommends that infants be exclusively breastfed, without supplemental solids or liquids, the first six months of life and that breastfeeding continue for at least one year of life and beyond. Recent studies estimate that suboptimal breastfeeding in the U.S. results annually in more than 900 preventable infant and child deaths, more than 4,000 premature deaths in women, and more than $31.2 billion in direct and indirect health-related costs.

Improving breastfeeding outcomes is integral to DSHS' overall efforts to promote better birth outcomes across the state. DSHS provides education and support directly to breastfeeding mothers, community stakeholders, birthing facilities, and worksites to reduce known breastfeeding barriers and build an environment around mothers that supports them to achieve their personal infant feeding goals. DSHS has numerous breastfeeding activities that are coordinated through the Infant Feeding Workgroup. DSHS will continue to invest in the following efforts to develop effective interventions:

- Multi-faceted approaches to improving maternity care practices in infant nutrition, including the *Right from the Start* awareness campaign for hospitals;
- The Texas Ten Steps designation that recognizes hospitals that have begun to make improvements;
- The Texas Ten Step Star Achiever Initiative, that provides a hospital learning collaborative, technical assistance, tools, and community connections to assist participating facilities to accelerate integration of recommended policies and practices and improve outcomes;
- Breastfeeding trainings for healthcare and childcare professionals; and
- Supplemental Nutrition Program for Women, Infants, and Children (WIC) *Every Ounce Counts* campaign, Lactation Support Hotline, and Mother-Friendly Worksite initiatives, which target educating the public, providers, and mothers about best practices to support breastfeeding.

Medicaid Incentives for Healthy Behaviors

The Centers for Medicare and Medicaid Services is conducting a grant-funded demonstration to evaluate the effectiveness of providing incentives to Medicaid

clients to encourage them to adopt healthy behaviors and improve outcomes. DSHS and the Health and Human Services Commission (HHSC) partnered to receive a five-year grant for $9.9 million. The project, known as Wellness Incentives and Navigation (WIN), focuses on non-elderly, non-Medicare eligible STAR+PLUS clients with severe mental illness or other mental health and substance use conditions coupled with chronic physical health diagnoses. WIN project goals include improved health self-management, increased use of preventive services, and more appropriate use of health services. Examples of potential individual goals include reduced tobacco use, improved diabetes management, better weight control, and improved stress management.

DSHS manages WIN on a day-to-day basis, with oversight by the HHSC Medicaid/CHIP Office. WIN has been implemented in the Harris managed care service area, in partnership with the STAR+PLUS health maintenance organizations and other community stakeholders. The project includes over 1,250 voluntary participants, randomized into intervention and control groups. WIN employs a complement of person-centered incentives to help participants manage their chronic health conditions. These include:

- Wellness planning and navigation facilitated by trained, professional health navigators, who use motivational interviewing techniques to help participants define and achieve their health goals;
- A flexible wellness account of $1,150 per year, per participant, to support specific health goals defined by the participant, with purchases authorized by the navigator; and
- More intensive Wellness Recovery Action Planning training for individuals who choose it.

9.3.2 Improving Health Through Safety Net Services

<u>Strategic Priority: Improve and protect the health and well-being of Texans.</u>

- Improve access to effective services across systems for behavioral health, including prevention, treatment, and recovery services, and integrate physical and behavioral health services.
- Improve access to preventive health care and family planning services for women.

<u>Strategic Priority: Create opportunities that lead to increased self-sufficiency and independence.</u>

- Partner with people with disabilities, including people with behavioral health issues, in overcoming barriers to full participation in the community and the workforce.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service delivery for people to receive timely, appropriate services.
- Explore opportunities to address co-occurring issues across disciplines and consider integrated service and treatment alternatives.

Discussion

DSHS promotes optimal health for individuals and communities by providing effective public health services, clinical services, mental health services, and substance abuse services. Responsibilities include coordinating a statewide network of services available through DSHS and its partners, ranging from population-based services to individualized care. See Section 9.5 for more information about some of these safety net services.

Through contracts with providers, DSHS seeks to ensure that Texans have access to health services, prevention, and treatment. This includes:

- Behavioral health services;
- Primary health care, including direct medical care for women and children with limited resources;
- Public health services; and
- Nutrition services.

DSHS provides specialized health services to targeted populations, including children with special health care needs, high-risk pregnant women, and persons with epilepsy, hemophilia, and end-stage renal disease. DSHS coordinates the training and certification process for community health workers who provide outreach, health education, and referrals to local community members. Additionally, DSHS works with healthcare providers and communities to improve access to care for the underserved, by recruiting and retaining providers to practice in federally designated shortage areas and expanding new and existing federally qualified health centers. Finally, DSHS works to build healthcare capacity in communities by providing technical assistance to organizations applying for certification as emergency medical services providers and state trauma centers.

Planned Actions

Women's Health and Primary Health Care

DSHS is implementing the Expanded Primary Health Care (EPHC) Program to increase access to women's health services statewide. EPHC services include six priority diagnosis and treatment services: emergency care; family planning; preventive health, including immunizations; health education; laboratory, X-ray, and

nuclear medicine; and other appropriate diagnostic services. Other services may include nutrition, health screening, home health care, dental care, transportation, prescription drugs and devices, durable supplies, environmental health, podiatry, and social services. The EPHC Program has a particular focus on family planning, breast and cervical cancer services, prenatal services, and prenatal dental services, in addition to other preventive and primary care services.

The 83rd Legislature appropriated $100 million in general revenue to DSHS over the 2014–2015 biennium for the creation of the EPHC Program. The program will expand primary and preventive care services to an additional 170,000 women, ages 18 and older, of which approximately 101,000 (60 percent) will be family planning clients.

Capacity of Inpatient Psychiatric Hospitals

DSHS operates and maintains state-owned facilities, which provide direct services 24 hours per day, 7 days per week to individuals requiring inpatient or residential services. Some facilities need increased 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, which results in a corresponding reduction of beds for civilly committed patients. Individuals with forensic commitments have committed crimes and are not competent to stand trial or were found not guilty by reason of insanity. These individuals are committed to state hospitals for treatment and competency restoration. From fiscal year 2001 to January 2014, the percentage of forensic bed use has increased from 16 percent to slightly over 50 percent in all state hospitals, including a new mental health treatment facility in Montgomery County. In January 2014, a snapshot of the patient population showed 1,214 forensic patients and 1,204 civil patients hospitalized in the system.

Texas Resilience and Recovery

Texas Resilience and Recovery (TRR) is a data-driven system for identifying, creating, and promoting best practices for the effective and efficient delivery of behavioral health care. People with serious and persistent mental illness can be high utilizers of general hospitals, emergency rooms, and long-term care facilities, such as nursing homes; they can also be more frequently incarcerated in the criminal justice system. Using TRR, the statewide behavioral health system has been structured to promote recovery and provide access to behavioral health services as a cost-effective alternative to these settings.

TRR matches availability and intensity of services with need through a uniform assessment that is built upon nationally used instruments (Adult Needs and Strengths Assessment and Child and Adolescent Needs and Strengths Assessment). Data about assessment and treatment services are used to measure provider performance and individual client outcomes, to respond to legislative

reporting requirements, and to continually monitor and improve the quality of services. TRR focuses on several key outcomes, including avoiding hospitalization and criminal justice involvement, achieving housing stability and employment, and improving overall functioning. To achieve these outcomes, each level of care integrates evidence-based practices and best-practice curricula designed to ameliorate symptoms, enhance skills, and empower persons served to meet individual recovery goals. Understanding that recovery is not a linear process, TRR provides flexibility for personal preference and clinical judgment in order to be consistent with an individual's strengths and the recovery process. The system also incorporates crisis services as needed to address higher periods of need and minimize unnecessary incarceration, use of emergency rooms, and admissions to hospitals.

Recovery-Based Support and Services

DSHS is developing a statewide approach to recovery referred to as Recovery Oriented Systems of Care (ROSC). This involves a re-orientation of approaches to the long-term resolution of mental health and substance use disorders. The ROSC vision focuses more on personal possibilities than pathologies, and more on continuity of long-term support in natural community relationships than the intensity of short-term professional interventions. ROSC is an approach to expanding and integrating diverse forms of helping individuals in the community. The ultimate measure of ROSC is not the size and scope of professional services but a community's capacity for compassion, support, and inclusion. DSHS is funding recovery support services to continue its commitment to the development of long-term recovery within ROSC communities around the state. Examples of recovery support services include coaching, check-ups, and housing and transportation assistance.

Youth Empowerment Services Waiver

The Health and Human Services Commission (HHSC) and DSHS received approval by the federal government to implement a 1915(c) Medicaid waiver. The program, called Youth Empowerment Services (YES), allows more flexibility in the funding of intensive community-based services and supports for children with serious emotional disturbances and their families. Community-based services include family support and respite, adaptive aids and supports, minor home modifications, community living support, specialized therapies, and transitional services.

DSHS implemented the YES waiver in April 2010 in Travis and Bexar Counties, with the local mental health authority (LMHA) in each county serving as the waiver provider agency. In July 2012, the program expanded to Tarrant County, with the LMHA providing local administrative oversight and Youth Advocate Programs, Inc. providing waiver services. In February 2014, the program expanded to the Houston area, including Brazoria, Fort Bend, Galveston, and Harris counties. In June 2014, the waiver program is tentatively scheduled to be implemented in Jim Hogg, Starr,

Webb, Zapata, Cameron, Hidalgo, and Willacy counties. DSHS and HHSC connect with the Department of Family and Protective Services (DFPS), Texas Department of Criminal Justice, and community stakeholder groups regarding program expansion to ensure timely referral of clients for community-based services.

Substance Abuse Intervention for Parents

DSHS is funding programs that provide access to substance abuse intervention services for parents prior to involvement or currently involved with DFPS. The DSHS-funded Outreach, Screening, Assessment, and Referral programs are required to acknowledge DFPS-referred clients by providing screening and assessment services no later than 72 hours after receiving the referral from DFPS. When DFPS refers an individual who is not in need of formal treatment services, that individual is evaluated for intervention services offered through the Pregnant and Postpartum Intervention (PPI) Program for women or the Parenting Awareness and Drug Risk Education (PADRE) Program for men. DFPS may also directly refer to DSHS-funded treatment providers, which are required to make services available no later than 72 hours after receiving the referral from DFPS.

DSHS has expanded eligibility in the PPI Program to include not only women who have or are at risk for developing a substance use disorder who are pregnant and/or have children younger than 18 months, but also those involved with DFPS who have children younger than age six. PADRE provides substance abuse intervention for fathers involved with DFPS with children younger than age six, similar to the PPI Program. Both programs offer gender-specific case management, home-visitation, and counseling services using a motivational interviewing approach. The programs aim to:

- Improve birth outcomes, especially those related to neglect or delay of healthcare stemming from substance use or misuse;
- Reduce the risk of substance exposure for future children;
- Increase recovery capital;
- Improve overall child health, including physical health and emotional safety in the home environment;
- Increase independence by linking to community resources; and
- Reduce the incidence of child abuse and neglect.

Targeted Mental Health Services for Children

DSHS purchases ten beds, on an ongoing basis, in private residential treatment centers (RTCs) across Texas. This provides an alternative to relinquishing custody of a child to DFPS for families who otherwise could not afford to obtain RTC services. When DFPS identifies children who are at risk of relinquishment of custody by their parents, this collaborative project allows DFPS to refer the children to DSHS. All allegations of abuse and neglect have been ruled out in these families.

Through this program, DSHS coordinates mental health assessments and RTC placement for the children whose emotional disturbance meets RTC criteria. DSHS funds room and board expenses for the children, and Medicaid pays for the clinical services. Outpatient services are coordinated for children whose mental health needs do not meet RTC criteria. At the conclusion of RTC services, children are reunified with their families and promptly receive an array of outpatient services designed to assist them and their families in maintaining the treatment gains achieved in the RTC.

9.3.3 Enhancing Public Health Response to Disasters and Disease Outbreaks

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

- Continue to improve disaster prevention, preparedness, and response.

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

- Create a regulatory environment that fosters the health, safety, and opportunities of Texans while ensuring a pro-business approach that supports accountability and innovation.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.
- Recruit, retain, and motivate the health and human services workforce by investing in employees with exemplary performance and by providing opportunities for professional development and advancement.

Discussion

Texas faces many different public health emergency situations, including severe disease outbreaks; major industrial accidents; and natural disasters like hurricanes, floods, and tornados. Public health preparedness is the process of enhancing

readiness and assuring an effective public and behavioral health and medical response to these threats. In a state the size of Texas, with diverse urban and rural communities, planning and response activities require close coordination with local, regional, state, and federal stakeholders. DSHS is the lead agency for coordinating these health and medical preparedness and response activities in Texas, which include community and healthcare systems resilience, emergency operations coordination, biosurveillance, information management, medical countermeasures management, support for increased demands on healthcare systems, responder health and safety, and mass fatality management.

Planned Actions

Public Health Emergency Preparedness and Response

DSHS coordinates a statewide public health preparedness and response program to address the public and behavioral health and medical response to all hazards, including natural disasters, major accidents, and terrorist acts. DSHS preparedness and response activities rely heavily upon collaborative partnerships with multiple disciplines across a variety of agencies and jurisdictions. DSHS will continue to build local, regional, and state response capabilities and improve plans and procedures for effective response.

Epidemiological Surveillance Capacity

Epidemiology is essential for the detection, control, and prevention of major health problems, in both emergency and non-emergency situations. Effective preparedness and response depends on:

- Case reporting of relevant conditions, injuries, exposures, and diseases;
- Detecting significant health threats such as unusual disease clusters;
- Conducting and documenting investigations of outbreaks and acute environmental exposures; and
- Providing public health recommendations to mitigate adverse effects.

Epidemiologists serve a critical role in surveillance, investigation, and response. DSHS monitors the retention and recruitment of epidemiologists to ensure the adequate capacity to conduct epidemiological surveillance.

Outbreak Response

In response to infectious disease outbreaks, DSHS works in partnership with epidemiologists, laboratorians, public health officials, and many local, state, and federal agencies. DSHS staff investigates outbreaks of healthcare-associated infections and food-borne, water-borne, respiratory, zoonotic, and vaccine-preventable diseases. Staff works to ensure rapid detection of an outbreak and a coordinated response. DSHS continues to refine a structured framework within

which outbreaks are effectively investigated, mitigation measures are put into place, and, where possible, measures are undertaken to prevent similar outbreaks in the future.

Food Safety

More than 200 known diseases are transmitted through food, including salmonellosis, listeriosis, Escherichia coli, and campylobacteriosis. It is estimated that food-borne disease causes approximately 3.8 million illnesses, 10,240 hospitalizations, and 240 deaths in Texas each year.

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. There may be manufacturing, distributing, and/or retail facilities that are not licensed, whether willfully or though ignorance of the law. 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 the retail firms are licensed and inspected by local health departments.

When an illness, injury, or outbreak occurs despite best efforts, DSHS has capabilities using federal, state, and local partnerships to respond quickly to the event, identify the cause, and implement measures to prevent further illness or injury. DSHS will continue to work with partners at all levels to further strengthen the food safety system.

Laboratory Capability and Capacity

The DSHS Laboratory provides testing support for disease surveillance, outbreak response, and other public health investigations. In the last two years, the DSHS Laboratory has provided testing for multiple food-borne outbreak investigations, the West Nile virus outbreak, an investigation of a compounding pharmacy's product, and multiple other infectious disease investigations. The DSHS Laboratory must be able to provide reliable test results quickly for decision-makers to determine a course of action. To provide an efficient and effective support for these activities, the DSHS Laboratory:

- Seeks to recruit and retain highly trained staff,
- Assesses new testing methods, and
- Evaluates new testing technologies that will improve efficiency and accuracy.

9.3.4 Addressing Emerging Changes in the Health Delivery System

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

- Improve access to effective services across systems for behavioral health, including prevention, treatment, and recovery services, and integrate physical and behavioral health services.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.
- Continue to enhance interagency partnerships, coordination, and information-sharing in addressing clients' complex needs.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.
- Use technology and other means to maximize work efficiency and eliminate costly maintenance and repair on unneeded or underutilized office space.

Discussion

Beginning in January 2014, greater availability of health insurance to individuals historically served by public health programs impacts how public health departments offer clinical services. Individuals have access to a broader array of providers and specialists and coverage of certain essential health benefits, including preventive services, maternity care, and certain immunizations. These changes, as well as the promotion of new healthcare delivery models and the focus on quality and cost of healthcare services, may change the environment of public health overall.

Local healthcare delivery systems may also experience changes in the way they operate due to the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, overseen by the Health and Human Services Commission (HHSC). The waiver includes two funding streams being distributed to hospitals and other providers.

- An uncompensated care pool reimburses hospitals and other providers for uncompensated care costs as reported in the annual waiver application/uncompensated care cost report.

- A Delivery System Reform Incentive Payment pool gives hospitals and other providers incentives to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness.

Mental illness and substance abuse remain challenges for Texas families and communities. Increased appropriations during the past three legislative sessions have allowed DSHS to increase funding for mental health services in communities and to provide opportunities for innovation. The agency has taken steps to ensure that state hospitals provide quality care, including making changes to the hospital environment and enhancing staff training and supervision. DSHS continues to analyze trends and systemic issues that impact client safety and to implement changes when needed.

Planned Actions

Ten-Year Plan—Modernized Service Delivery System

DSHS is developing a ten-year plan for the provision of psychiatric inpatient hospitalization. DSHS currently provides inpatient psychiatric care at nine state-owned psychiatric hospitals and one residential treatment facility for adolescents. The ten facilities are on eleven campuses located in Austin, Big Spring, El Paso, Harlingen, Kerrville, Rusk, San Antonio, Terrell, Waco, Wichita Falls, and Vernon. The North Texas State Hospital is located at two campuses in Vernon and Wichita Falls.

The plan will address operational needs, including infrastructure needs of the existing facilities, future infrastructure needs, capacity needs across various regions of the state, and associated costs. The plan will also consider:

- Current state-funded hospital capacity;
- Timely access to services in the least restrictive, clinically appropriate environment;
- Best practices for inpatient psychiatric care;
- Opportunities for patients to receive services near their home; and
- Efficient use of state resources.

DSHS will use a contractor to provide technical expertise and will consult with stakeholders during the development phase. DSHS will also collaborate with the Department of Aging and Disability Services on the development of the plan, which is due December 1, 2014.

Medicaid and Mental Health Integration

DSHS provides rehabilitation and case management Medicaid services under a fee-for-service model. Although HHSC expanded the Medicaid managed care model

statewide in March 2012 via the 1115 Transformation Waiver, Medicaid rehabilitation and case management services remain “carved out” of managed care.

Senate Bill 58 (83-R) “carves in” rehabilitation and case management services into the Medicaid managed care system. This provides an opportunity to better integrate behavioral health care with physical health care and to expand the provider base for rehabilitation and case management services. HHSC is currently leading activities to implement this legislation. DSHS has been working collaboratively with HHSC to ensure a timely and smooth process.

Implementation of Medicaid 1115 Transformation Waiver Project

As part of working with HHSC to implement the 1115 Transformation Waiver, DSHS is participating in the Delivery System Reform Incentive Payment project to implement innovative testing and treatment options for latent tuberculosis infection (LTBI) in a portion of south central Texas. This project will employ the following methods:

- Increasing targeted testing for LTBI in high risk populations;
- Providing routine testing for LTBI with interferon gamma release assays instead of tuberculin skin testing to minimize false positive tests;
- Providing routine treatment of LTBI through a 12-dose, 12-week regimen administered by directly observed therapy; and
- Facilitating hospitalization for care of those few patients who cannot be successfully treated as outpatients.

With the opportunity to share best practices with providers through learning collaboratives, this project may lead to the implementation of best practices related to LTBI testing and treatment throughout the state.

9.3.5 Protecting Consumers through Regulation

<u>Strategic Priority: Protect vulnerable Texans from abuse, neglect, and exploitation.</u>

- Ensure the safety and well-being of Texans in facilities regulated by, operated by, or provided via contract with the state, as well as those served in their homes.
- Create a regulatory environment that fosters the health, safety, and opportunities of Texans while ensuring a pro-business approach that supports accountability and innovation.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Continue to enhance the service delivery system to be more coordinated, innovative, cost-effective, and customer-friendly.

Strategic Priority: Ensure the integrity of health and human service providers.

- Optimize the prevention, detection, and correction of fraud, waste, and abuse, focusing on high-risk areas.

Discussion

DSHS regulatory programs ensure that individuals and business entities meet state minimum standards to engage in regulated activities. DSHS licenses health facilities and certain health professionals and regulates manufacturers and processors of consumer products, such as prescription drugs, medical devices, food, and the use of radiation in industry and medical offices.

Between 2002 and 2013, all regulatory strategies saw tremendous growth in the number of licensees; the overall increase was about 45 percent, exceeding the growth in the state's population. The total number of licenses overseen by DSHS exceeds 350,000, and continued growth is anticipated as the state population 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. DSHS regulatory activities impact Texas commerce, since regulated individuals cannot work and regulated firms cannot operate if they do not have statutorily mandated licenses. Processing times must be monitored carefully and managed quickly if they start to rise.

Planned Actions

Risk-Based Approach

Historically, DSHS regulatory programs have prioritized inspections, complaint investigations, and other compliance activities to address issues that are of the highest potential public health risk before other issues. With the continued rapid growth in the number of licenses and resource constraints, the risk-based approach continues to be critical to assure that DSHS resources are used in an efficient and effective manner. Regulatory efforts must remain protective of public health while still assuring that licenses are issued in a timely manner to allow individuals and businesses to operate. This has meant that DSHS no longer investigates some low-

risk complaints, refers more complaints to other entities for self-investigation, and performs fewer routine inspections. DSHS regulatory staff will continue to evaluate and refine risk matrices and tools to target limited resources to the programs that pose the highest risk to the public.

Expanded Use of Technology to Increase Productivity

For almost a decade, the Division for Regulatory Services has been working to automate and integrate its regulatory functions to the greatest extent possible. This began with development of the Regulatory Automation System (RAS), which consolidated more than 70 different licensing, compliance, and enforcement systems/databases. RAS established online service capabilities, including the submission of initial and renewal applications and public licensing searches. DSHS regulatory programs successfully migrated onto RAS over a six-year period ending in 2011. In 2012, DSHS initiated a mobile inspection pilot project for the Milk and Dairy Program and, in 2013, expanded RAS' capabilities by using cloud technology to access the database and applications through the Internet. During 2014, inspectors in four programs will be transferred onto mobile technology, which will allow inspections to be done on tablet personal computers that upload results directly into RAS databases, thus eliminating paper inspections and manual data entry.

Future plans include the transfer of the remainder of the regulatory inspection and complaint investigation programs onto mobile technology, as appropriate, and a campaign to increase stakeholder use of the online licensing option. In addition, DSHS is evaluating the use of a document management system, which would allow electronic documents to be submitted online or paper documents to be scanned and "attached" to a licensing file, reducing and eventually eliminating the need for large paper files and storage capabilities.

9.3.6 Expanding the Effective Use of Health Information

<u>Strategic Priority: Improve and protect the health and well-being of Texans.</u>

- Emphasize health promotion, disease prevention, early intervention, and primary care, in a quality-oriented, electronically enabled, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Continue improving the availability of timely and accurate information to support data-driven decision-making, and invest in systems to leverage the state's health information exchange network where appropriate.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Encourage communication, teamwork, and innovation.
- Ensure the security of agency data and privacy of client data.

Discussion

DSHS has been increasingly involved in state efforts to improve the quality and safety of health care in Texas. Initiatives involve the use of information technology for service delivery, quality improvement, cost containment, and increased patient control. Health communication and health information technology are central to health care, public health, and the way society views health. Expanding the use of health information among healthcare and public health professionals can facilitate quick and informed action to health risks and public health emergencies, as well as provide sound principles in the design of programs and interventions that result in healthier behaviors.

Planned Actions

Adult Potentially Preventable Hospitalizations

In 2012, adult Texans received approximately $8.1 billion in hospital charges for the following eight potentially preventable conditions: bacterial pneumonia, dehydration, urinary tract Infection, congestive heart failure, hypertension, chronic obstructive pulmonary disease or older adult asthma, diabetes short-term complications, and diabetes long-term complications. Hospitalizations for these conditions are considered potentially preventable because hospitalization would potentially have not occurred if the individual had access to, and/or cooperated with, outpatient health care.

Since 2008, DSHS has worked to provide user-friendly data and information to stakeholders on the impact of adult potentially preventable hospitalizations (PPHs) in Texas. The DSHS website, http://www.dshs.state.tx.us/ph, provides state and county profiles and maps, clinical interventions, and information about funded project sites. The 82nd and 83rd Legislatures appropriated $2 million each for DSHS to implement an initiative to reduce PPHs in the 2012–2013 biennium and the 2014–2015 biennium, respectively. DSHS contracted with 16 severely impacted counties to target one or more adult PPH conditions. Each county has a project contact, designated by the county judge, who leads a community coordinated approach, involving multiple health-related providers, to implement one or more evidence-based interventions.

Health Care Associated Infections Reporting

Chapter 98 of the Texas Health and Safety Code requires DSHS to compile and make available to the public a summary, by healthcare facility, of healthcare-associated infections (HAIs) reported by the facilities. The Texas Legislature has taken steps toward improving patient safety. Examples include Senate Bill (S.B.) 288 (80-R), S.B. 203 (81-R), and House Bill 3284 (83-R). Each of these initiatives share similar objectives: to assist consumers in making informed healthcare decisions and to minimize the administrative burden on facilities in reporting data.

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 (80-R) required DSHS to establish an HAI reporting system. In addition, this legislation charged DSHS with developing and publishing a summary of the infections reported by healthcare facilities, establishing an advisory panel, providing education and training for healthcare facility staff, and providing accurate comparison of HAI data to the public to help individuals make informed decisions about choosing healthcare facilities. These data are now available at www.haitexas.org.

Preventable Adverse Events Reporting and Patient Safety

S.B. 203 (81-R) requires the reporting of preventable adverse events (PAEs). The Centers for Medicare and Medicaid Services has established ten categories of hospital-acquired conditions (HACs) for which no additional payment is provided to the facility if the condition was not present on admission. Examples of HACs include catheter-associated urinary tract infections, deep vein thrombosis following certain orthopedic procedures, and surgical site infections following bariatric surgery for obesity.

The National Quality Forum (NQF) has identified 29 serious reportable events, known as “never events.” Examples of never events include unintended retention of a foreign object in a patient after surgery, surgery performed on the wrong body part, surgery performed on the wrong patient, patient death or serious disability associated with a medication error, and patient death or serious disability associated with a fall while being cared for in a healthcare facility.

The patient safety initiative includes development of a secure, web-based reporting system for over 1,000 hospitals and ambulatory surgery centers to report the NQF serious reportable events identified. The system developed for PAE will also enable hospitals to report HACs or events for which the Medicare program will not provide additional payment to the facility. The initiative includes development of a website to display incidence of PAE by hospital and surgery center.

Geographic Information Systems

The Center for Health Statistics and the Division for Regional and Local Health Services support the agency's use of Geographic Information System (GIS) technology to improve the health of Texans. Services provided to other DSHS programs include custom mapping, geocoding (linking address files to geographic coordinates and converting to map data), geographical analysis, and technical assistance.

GIS technology uses computers and software to represent graphically the relationship between spatial location and database attributes. GIS provides the ability to visualize data spatially using maps that allow interpretation of data in ways not possible in a tabular form. GIS is used to allocate resources better, improve decision-making, and interpret geographic data. Specific examples include:

- Analyzing spatial variations in health outcomes;
- Selecting new clinic locations based on selected factors;
- Conducting risk assessments;
- Assisting with emergency response efforts;
- Evaluating the availability of health care;
- Mapping confidential information by aggregating to census tract, county, or other spatial unit;
- Mapping provider locations in relation to other variables;
- Tracking the spread of disease;
- Understanding environmental causes of disease; and
- Providing mapping services for research.

Data-Driven Decision-Making

The Division for Mental Health and Substance Abuse Services is committed to providing all interested stakeholders detailed information on the quality of state-funded mental health and substance abuse services. This commitment was advanced by S.B. 126 (83-R). DSHS measures mental health and substance abuse providers on both the quality and quantity of services and the outcomes, or benchmarks, DSHS expects state-contracted providers to reach and maintain.

Mental Health Contract Performance Measure Report

This report provides a snapshot of how each community mental health center is meeting measures to provide an environment for client recovery, including supportive housing and employment. Adult and child/adolescent data are included on both a comprehensive spreadsheet and on individual sheets that allow comparison of how each center is doing.

NorthSTAR Mental Health Contract Performance Measure Report

This report provides an overview of how well ValueOptions, the contractor for NorthSTAR, is providing services to its constituency in the Dallas service area. The report includes adult and child/adolescent data for certain contract measures, including jail diversion and length of stay for substance use disorder treatment.

Substance Abuse Contract Performance Measure Report

This report provides a snapshot of how each substance abuse prevention, intervention, and treatment services provider is meeting contract-specified measures to provide an environment for client recovery. Adult and youth data are included.

Health Status of Texas Report

DSHS developed a new report, *The Health Status of Texas*, quantifying significant disease trends in the state. The report estimates the disease burden across major population groups and describes trends over time that impact efforts to protect the health of millions of Texans. The report, updated on an annual basis, is available at http://www.dshs.state.tx.us/chs/datalist.shtm. The next update will be available in August 2014.

9.3.7 Forming Effective Partnerships through Leadership

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

- Improve access to effective services across systems for behavioral health, including prevention, treatment, and recovery services, and integrate physical and behavioral health services.

Strategic Priority: Encourage partnerships and community involvement.

- Develop community partnerships with individuals, families, stakeholders, providers, and faith- and community-based organizations to improve service design, programs, policies, and delivery for people to receive timely, appropriate services.
- Further expand partnerships with institutions of higher education to foster collaborative efforts and workforce development.

Strategic Priority: Promote good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, integrity in business processes.

- Provide an accessible, secure, and safe work environment, including training for employees to respond appropriately to difficult or dangerous situations, whether in the office or in the field.

Discussion

Health and human service stakeholders play an important role in helping DSHS accomplish its mission of improving the health and well-being of Texans. DSHS uses stakeholder input to inform policy decisions, to improve service delivery, and to enhance communications. In addition to holding stakeholder meetings to seek input on specific topics, DSHS routinely seeks advice and recommendations from advisory committees that have been established by state statute, by federal requirements, or in response to emerging issues. Examples of advisory committees that inform agency decision-making are included in Chapter 4, in Section 4.4, Councils, Committees, and Task Forces.

Efforts are underway to establish new partnerships and build upon existing relationships with the many agencies and organizations involved with DSHS programs and clients served. DSHS also recognizes the importance of collaborating with institutions of higher education to strengthen the link between practice and research, as well as to develop the public health and behavioral health workforce.

Planned Actions

Collaboration with Local Health Departments

In accordance with Chapter 117 of the Texas Health and Safety Code, DSHS is committed to maintaining and enhancing a continuous collaborative relationship with local health departments throughout the state. Specific priority is placed on several initiatives, including:

- Supporting the Public Health and Funding Policy Committee to provide policy-level advice and assistance to DSHS in the organization and funding of local public health in Texas and the relationship between local public health entities and the department;
- Providing direct support and technical assistance to local health entities through DSHS health service regions to assure seamless and effective delivery of essential public health services to communities in all parts of the state;
- Enhancing education and training programs for local health authorities operating in every Texas county;

- Assuring regular and effective information-sharing between DSHS programs and regions with local health entities; and
- Facilitating and assisting local health departments seeking voluntary accreditation through the national Public Health Accreditation Board, an independent accrediting body for tribal, state, local, and territorial public health departments.

Collaboration with Health Insurance Providers

DSHS recognizes the key role that insurance agencies and health maintenance organizations play in improving health and well-being of Texans. In an effort to facilitate more effective collaboration, DSHS meets quarterly with the medical directors of the top health insurers in the state. Topics discussed have included healthcare-associated infections, immunizations, chronic disease prevention, screening for substance abuse and mental health disorders in primary care settings, and public health and medical preparedness. Most recently, many of the insurance companies have signed a letter acknowledging their support of a coordinated and comprehensive approach to improve perinatal health outcomes through a variety of strategies that include:

- Promoting healthy behaviors through education and support;
- Early identification and case management of high-risk pregnancies;
- Providing reproductive health services, including preconception and inter-conception care services and promotion of breastfeeding practices and policies; and
- Assuring woman- and family-centered approaches to immunizations.

Continuing Education

As the state agency responsible for public health and behavioral health, DSHS has a leadership role in providing information and competency-based education to keep agency staff and health professionals across the state updated on subject matter and practice issues under the agency's purview. DSHS engages in collaborative and cooperative relationships with other state agencies, federal agencies, academic medical centers, medical professional societies, physician practices, community organizations, hospitals, municipal agencies, and education partners to promote continuous improvement in patient care and population health.

Continuing education credits are provided to over 35,000 health professionals annually, both internal and external to the agency, including physicians, nurses, social workers, registered sanitarians, licensed chemical dependency counselors, licensed marriage and family therapists, licensed professional counselors, and certified health education specialists. The DSHS Continuing Education Service assesses, through established competencies, the knowledge and skill deficiencies of

the public health workforce and uses that assessment to guide decisions regarding the type and level of training provided.

9.4 Internal Challenges and Opportunities

9.4.1 Developing Quality Improvement Initiatives for Key Business Processes

Discussion

Improving key business processes is a critical ongoing activity for DSHS employees. DSHS has developed business processes to meet the agency's goals and objectives established by the Texas Legislature and, in many cases, by laws and rules established by federal agencies. DSHS continually reviews its operations and seeks ways to function more effectively. The goal is to use resources wisely and to deliver services in the most efficient manner. DSHS continuously seeks to find efficiencies in its business practices to maximize achievement of its mission. DSHS is reviewing key business processes in order to contain costs, improve efficiencies, streamline procedures and systems, and enhance performance.

Planned Actions

National Public Health Improvement Initiative

In 2010, Texas received a National Public Health Improvement Initiative grant from the Centers from Disease Control and Prevention to transform the Texas public health system and increase performance management capacity. Initially, the grant had a five-year timeline for implementing quality improvement activities across the agency. The state received $2,400,000 the first four years. Although the grant ends September 2014, several initiatives now have the foundation to sustain the progress made to date.

DSHS formed a quality improvement team to develop and review an annual agency-wide quality improvement plan. The team conducted an initial quality improvement self-assessment and quality improvement training. The team has also provided leadership for the following accomplishments:

- Training over 180 staff through Quality Champions Training,
- Streamlining the contract procurement process,
- Improving the Lead Registry data collection,
- Improving the accessibility of health data,

- Increasing local health departments' readiness for public health accreditation, and
- Presenting return-on-investment training for Chronic Disease Program analysis.

DSHS will continue the emphasis on quality improvement as this initiative transitions from a grant-funded program to a self-sustaining activity.

Health Information Systems Governance Redesign Initiative

DSHS has undertaken an initiative to redesign its information technology (IT) governance processes. In 2013, DSHS conducted an IT governance functional assessment and gap analysis and identified areas for improvement. The Health Information Systems Governance Redesign (HISGR) Initiative is one of several efforts to improve the effectiveness and efficiency of DSHS operations.

The overall purpose of the HISGR Initiative is two-fold:

- Creating an agency-wide governance process that establishes commissioner and executive direction and oversight for all health information systems and IT investments across the agency; and
- Establishing governance committees, policies, and operating procedures that intentionally align health information systems with the agency's strategic health priorities, including health IT priorities.

The practical result of the redesign process is a change to the governance policies, procedures, tools, and organizational structures of IT oversight committees. Ultimately, by making decisions about IT resources that align around shared agency priorities, the new governance process will also reduce duplicative systems by leveraging existing technical architecture. This will also result in faster implementation of future projects and allow more efficient use of funding.

Contract Process Improvement Initiative

The goal of the Contract Process Improvement Initiative is to make the agency's contracting process easier and faster—with a target of at least a 25 percent reduction in the cycle time for contracts and resulting cost savings. The initiative has enabled a comprehensive mapping of the contracting process. The implementation plan includes the following recommendations:

- Proposed adoption of revised contracting process beginning in the fiscal year 2014 contracting period,
- Use of an electronic contracting system and contractor portal that is currently used by another state agency,
- Continuous evaluation of implementation by Internal Audit, and
- Review of opportunities to consolidate functions and duties across the agency once the system is in place.

9.4.2 Addressing Current and Future DSHS Workforce Needs

Discussion

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.

Potential significant changes in the labor market, or in healthcare policy, could jeopardize the acquisition, development, deployment, and retention of the DSHS workforce. DSHS will continue to collaborate with institutions of higher education to attract candidates with specialized education and training in public health and behavioral health. The ability to survive competition in other sectors of the labor market will rest upon comprehensive strategic initiatives and optimizing workforce management.

Planned Actions

Mental Health Workforce

DSHS is committed to aiding stakeholders and policymakers in addressing the state's mental health workforce shortage. As a part of ongoing efforts to track Texas' supply of healthcare providers, the agency collects, analyzes, and disseminates mental health workforce supply data. These data are used to identify means of expanding the mental health workforce and improving the recruitment and retention of mental health practitioners, including psychiatrists, nurses, and other providers. DSHS has identified five core initiatives to address Texas' mental health workforce shortage:

- Expanding the mental health workforce overall,
- Improving distribution of services throughout the state,
- Attracting more ethnic and linguistic diversity into the mental health workforce,
- Identifying educational reforms leading to better preparation of mental health practitioners, and
- Improving data collection related to the need for and provision of mental health services.

Psychiatric Nurse Assistants in State Hospitals

The state hospital system has historically experienced high vacancy and turnover rates for psychiatric nurse assistant (PNA) positions. During the first quarter of fiscal year 2014, DSHS implemented a ten percent salary increase for all PNAs. As a result, the vacancy fill rate increased, but the turnover rate remained the same.

DSHS will monitor the effect of the increase for this position in an effort to continue to decrease the vacancy and turnover rate.

Preventive Medicine Residency Program

The Office of Academic Linkages recruits and trains physicians through the Preventive Medicine Residency Program. This two year, full-time residency program is accredited by the Accreditation Council for Graduate Medical Education. Preventive medicine specialists are licensed medical doctors or doctors of osteopathy who possess core competencies in biostatistics, epidemiology, environmental and occupational medicine, planning and evaluation of health services, management of healthcare organizations, research into causes of disease and injury in population groups, and the practice of prevention in clinical medicine.

The intent of DSHS is to train future leaders of Texas public health and retain qualified physicians for productive preventive medicine careers at DSHS. The Office of Academic Linkages collaborates with other DSHS divisions, health service regions, other state agencies, education institutions, and healthcare facilities and organizations to enhance the educational and clinical experiences of program participants.

Psychiatric Residency Positions

The 83rd Legislature appropriated $2 million for the 2014–2015 biennium toward funding psychiatric residency slots at both state psychiatric hospitals and local mental health community centers. Six hospitals and four community centers will partner with psychiatric residency programs at colleges and universities that are accredited by the Accreditation Council for Graduate Medical Education. The purpose of the funding is to train and recruit psychiatrists to work in public mental health settings in order to address staff shortages in those settings.

Student Internships and Practicums

DSHS provides educational experiences via graduate-level practicums and undergraduate internships representing over 50 undergraduate and graduate degrees in addition to professional training and certification programs. These degrees and disciplines include biology, medical and lab technology, nursing, psychiatry, family practice, preventive medicine, public health, health administration, community health and health promotion, chronic disease, medical geography, and other health-related specialties. In 2013, 1,935 students, representing more than 75 university systems and colleges, received educational experiences at DSHS for a total of 138,593 student hours.

The Office of Academic Linkages has developed a Blue Ribbon Internship Program. Partnering universities screen and select highly qualified students to participate in the program for a semester. During the internship, students have the opportunity to

facilitate and participate in goal-oriented, semester-long policy, program, and/or research projects in a practice setting under the supervision of seasoned public health and behavioral scientists and practitioners. In addition to gaining program, policy, and/or research experience, interns gain communication skills by preparing both written and oral presentations about their projects. In 2013, ten students participated in the Blue Ribbon Internship Program.

9.4.3 Enhancing the Use of Technology and Health Data-Sharing

Discussion

DSHS must continue to ensure it has secure health information systems to support public health activities, improve healthcare quality, and control costs.

Public health data are central to health policy decision-making. The collection, analysis, dissemination, and reporting functions associated with health data occur throughout DSHS and the Health and Human Services System. Vital statistics and other data are at risk for fraud; therefore, data collection and sharing require standards that protect patient privacy, data confidentiality, and system security.

The DSHS statewide information technology (IT) network supports the delivery of public health services by supporting 12,000 employees in 160 locations. DSHS IT also supports delivery of participant services to 534 clinics in 227 counties for the Special Supplemental Nutrition Program for Women, Infants, and Children. DSHS has made significant investment in the network infrastructure to ensure reliability, performance, security, and connectivity redundancy to avoid data losses and service interruption. DSHS has enhanced data security through the deployment of infrastructure for email filtering, intrusion detection, software patch management, encryption, and laptop computer tracking.

The strategic focus is shifting to availability, quality, accessibility, security, and sharing of data. DSHS is currently re-engineering or remediating systems to include requirements for web-enabling, standards-based architecture, federal and state rules compliance, and interoperability for data-sharing. 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.

Planned Actions

Security of Birth Records

DSHS, in conjunction with a workgroup established as a provision of DSHS's Rider 72 of the 2012–2013 General Appropriations Act (82-R), developed a set of recommendations that addresses the security and effectiveness of the state's birth record information system. Specifically, the workgroup:

- Evaluated the effectiveness and security of the state's birth record information system;
- Evaluated the feasibility of restructuring and upgrading the birth record information system and documents with advanced technology to prevent fraud and reduce inefficiency;
- Identified the roles and responsibilities of DSHS, local governments, and others in a central issuance birth record information system; and
- Identified ways to leverage private sector investment and user fees to restructure and upgrade the birth record information system and documents without the use of general revenue funds.

In fiscal year 2013, DSHS operationalized the findings of the workgroup, recommendations for change, and considerations for implementing these recommendations as the Vital Statistics Business Modernization Program. The Vital Statistics Unit has already initiated some key recommendations. The Texas Electronic Vital Events Registrar project, which incorporates the technology recommendations, began in fiscal year 2013 and has a projected completion date of June 2016. Business process improvements for security and fraud prevention began in fiscal year 2013 and will be incorporated in daily operations as continuous quality improvement by fiscal year 2015. Additionally, statutory changes are needed to expand the State Registrar's oversight of local registry offices and licensed and non-licensed institutions in order to decrease opportunities for fraud, theft, or other methods to illegally obtain birth certificate copies.

Health Information Technology and Health Information Exchange

The Texas Statewide Plan for Health Information Technology (HIT), mandated by the federal Health Information Technology for Economic and Clinical Health (HITECH) Act 2009, requires broad adoption of electronic health records and electronic medical records. The DSHS technology infrastructure is critical to achieving public health performance measures. A health information exchange operating environment is one in which DSHS program operations are supported by IT systems that will:

- Enable health data exchange internally and externally, support advanced analytics to understand cost and improve healthcare quality, and enable data-driven decision-making;

- Ensure privacy, confidentiality, and security of all health data and compliance with regulatory requirements; and
- Provide an integrated HIT environment with timely exchange of data and information, agile response to changing demands, and a user-friendly portal for internal and external partners.

Privacy of Health Data

DSHS is addressing health data management policy as one component of the health information governance structure. This initiative focuses on developing the information architecture for DSHS, which is a comprehensive plan that governs the gathering, analysis, and exchange of health data in support of program operations. Effective implementation of this plan will require establishing the discipline of information management, which includes standards that govern all data-sharing, data use, data security, and consent and authorization.

Enhanced Data Security

The HITECH Act 2009 specifies that personal health information (PHI) must be protected. The specifications that cover how PHI must be encrypted in files on a computer are promulgated by the National Institute of Standards and Technology. To enhance the security of PHI, DSHS has been deploying end-point encryption throughout the agency infrastructure and working with the Health and Human Services Commission in the implementation of a systemwide data-loss prevention (DLP) solution. The DLP solution enables DSHS to proactively address reputational, operational, and IT risks to PHI through the use of a collaborative enterprise governance, risk, and compliance program and a central management system for identifying risks, evaluating their likelihood and impact, relating them to mitigating controls, and tracking their resolution.

9.4.4 Optimizing the Use of Resources

Discussion

Ensuring a well-maintained DSHS facilities infrastructure is necessary to provide a safe and secure environment for DSHS clients and workforce while protecting the long term value of the public's investment for housing the functions of state government. The ten mental health facilities are campus-style settings composed of more than 500 buildings ranging in ages from 16 to 156 years. Deterioration of one building system often causes accelerated deterioration of another, which may result in accelerated need for maintenance. Additionally, old, outdated building systems consume more energy than newer systems. Replacement of outdated and failing building systems with new, higher-efficiency equipment results in reduced energy costs. The buildings and their environments are a vital part of the services provided.

Failure of any major building system can result in emergency relocation of patients, which is not only difficult and costly, but also compromises the safety of patients.

Planned Actions

State Hospital Facilities Maintenance and Planning

Capital construction funding is necessary to maintain the existing facility infrastructure, meet client service needs, ensure continued accreditation by The Joint Commission for federal reimbursement, and reduce maintenance and energy costs. Critical infrastructure needs, including Life Safety Code, roofing, heating and air conditioning, electrical, plumbing, site utilities, and renovations to meet client programmatic requirements are needed. Priority is placed on buildings for client sleeping and client services, along with support buildings such as kitchens, laundries, and site utilities. A ten-year plan is being developed for the provision of psychiatric inpatient hospitalization services. The plan will address operational needs, including infrastructure needs of the existing facilities and future infrastructure needs. (See Section 9.3.4 for more information about the ten-year plan.)

9.5 Agency Goals: Target Populations and Services Descriptions

9.5.1 DSHS Goal 1: Preparedness and Prevention Services

Goal 1 programs focus on preventing chronic and infectious diseases; preparing, responding, and recovering from public health emergencies; and providing essential public health services for individuals and communities. In addition, Goal 1 includes epidemiological investigations and disease registries designed to:

- Provide the state with the basic health care information needed for policy decisions and program development,
- Address a particular disease, and
- Identify cases of disease for program evaluation and research.

Regional and Local Public Health Services and Systems

Target Population

The local and regional public health system serves all Texans.

Services Description

Local public health agencies and DSHS health service regions safeguard Texans' health by performing preventive, protective, and regulatory functions and effectively responding in an emergency or disaster. In the absence of local health departments or authorities, DSHS health service regions perform critical functions related to public health and preparedness, as well as work to reduce or eliminate health disparities in the state. Functions performed by the regional and local public health system include the following:

- Conducting activities associated with health education, promotion, and assessment of health disparities;
- Planning for and responding to local public health emergencies such as communicable disease outbreaks or hurricanes;
- Enforcing local and state public health laws;
- Performing communicable disease control measures, such as contact investigations for tuberculosis (TB), human immunodeficiency virus (HIV) and sexually transmitted disease (STD);
- Conducting active disease surveillance and epidemiological analysis; and
- Collaborating with local health departments across the state to support or enhance local public health efforts.

Community Preparedness

Target Population

Community preparedness serves the entire Texas population.

Services Description

Public health preparedness is the state of being ready for a natural disaster, major incident, disease outbreak, biological attack, or other public health emergency. The preparedness process includes development of plans and response guidelines, training staff assigned response duties, and performing drills and exercises to test the effectiveness of plans and training. It also includes management and maintenance of response stockpiles, supplies, and equipment. Response is the activation of key staff and deployment of response teams to manage the impact of a disaster or public health emergency and includes deployment of equipment and coordination of needed resources.

In recent years, DSHS has responded to a wide variety of disasters and public health emergencies, including:

- Hurricanes Dolly, Gustav, Ike, and Alex;
- Tropical Storm Eduard;
- The San Angelo Yearning for Zion Ranch event;
- The H1N1 pandemic;
- The Bastrop wildfires;
- The West Nile Virus outbreak; and
- The West Fertilizer Plant explosion.

DSHS has also responded to numerous investigations and responses to foodborne outbreaks, contaminated drug products, and infectious disease outbreaks, such as TB, measles, mumps, and pertussis.

DSHS coordinates the distribution of grant funds from the Centers for Disease Control and Prevention (CDC) and the federal Office of the Assistant Secretary for Preparedness and Response. These resources are allocated to the statewide network of trauma service areas and local and regional health departments to:

- Ensure that preparedness, response, and recovery operations are comprehensive, synchronized, and mutually supportive;
- Achieve progress on preparedness and response capability;
- Conduct jurisdictional risk assessments;
- Develop, implement, and evaluate preparedness and response planning;
- Conduct exercises and drills to assure planning effectiveness;
- Support and evaluate workforce development for key public health professionals, infectious disease specialists, emergency personnel, healthcare providers, and other response partners;
- Enhance surveillance, epidemiology, and laboratory capacities;
- Develop and implement effective risk communication strategies;
- Support hospitals and healthcare systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies; and
- Manage and deploy the DSHS Texas Critical Incident Stress Management Network, which responds to disasters and to the mental health needs of survivors and first responders.

DSHS develops model plans, standards, and guidelines to help regional and local jurisdictions address all four elements of emergency management: mitigation, preparedness, response, and recovery. Through this coordinated effort and in collaboration with emergency management and other response partners, DSHS leads public health and medical response activities for Texas.

Health Promotion and Vital Records

Target Population

Health promotion and vital records functions serve the entire Texas population.

Services Description

The provision of health information is critical to making effective state and local policy decisions related to health status improvement. Key to enabling policy decisions are the vital records and health registries maintained by DSHS, which describe life and health events, and which analyze and distribute information on health and healthcare systems.

Texas Birth Defects Registry

Chapter 87 of the Texas Health and Safety Code requires DSHS to maintain a birth defects registry for the state. The Texas Birth Defects Registry exists to identify and describe patterns of birth defects in Texas. Tracking the data provides information on the types of birth defects, how often, where, and in what populations they are occurring. This information can be used to identify the causes of birth defects, implement effective prevention and intervention strategies, conduct birth defect cluster investigations, develop patient education and outreach activities, and support future research activities.

Cancer Registry

Chapter 82 of the Texas Health and Safety Code requires DSHS to maintain a cancer registry for the state. Functions include:

- Maintaining a statewide population-based cancer registry for Texas;
- Analyzing, evaluating, and disseminating cancer data;
- Monitoring the health status of communities; and
- Monitoring changes in cancer incidence over time.

The Cancer Registry:

- Identifies population groups at increased risk of cancer;
- Provides data for cancer cluster investigations;
- Conducts epidemiological cancer studies;
- Evaluates the effectiveness of cancer control initiatives;
- Disseminates cancer information for etiologic research; and
- Supports cancer control planning and evaluation, education, and health services delivery.

Center for Health Statistics

The Center for Health Statistics (CHS) serves as the public health informatics hub for the State of Texas. CHS collects, manages, and analyzes health data and develops the systems by which stakeholders retrieve data. CHS disseminates health information by providing pre-research datasets via reports, briefs, and collaborative public health research and by producing info-graphic and geographic information system visualizations. CHS core functions include data collection, stewardship, and management; public health research; health information dissemination; and analytical consultation, technical guidance, public health informatics expertise, and geo-spatial analytics.

Vital Statistics Unit

Chapter 191, Health and Safety Code, requires DSHS to administer the registration of vital events for the State of Texas. The Vital Statistics Unit (VSU) houses, maintains, and safeguards more than 48 million records of important events in Texans' lives, including births, deaths, marriages, divorces, adoptions, and paternity changes.

VSU responds to customer requests for certified copies or verification of vital event records and other supplemental documents. VSU also responds to requests for information and verification of identity documents from the public and other governmental agencies and organizations. VSU produces documents that federal and state entities use to establish identity, citizenship, ownership, entitlement to benefits, and passport travel authorizations.

VSU issues more than one million record service transactions annually. The primary registration mechanism for birth and death vital events moved from a paper-based system to what is now almost entirely electronic. The Texas Electronic Registrar (TER) system reduced event registration times from 35 days to 5.5 days for birth records, and from 39 days to 11 days for deaths. In addition to vital record registration, VSU staff uses the TER system to manage and process customer orders, including fee tracking and management tasks. The TER system is deployed across registration districts and licensed institutions, including hospitals, birthing centers, funeral homes, medical examiners, and justices of the peace throughout Texas.

Border Health

Target Population

Border health functions serve the 2.7 million Texans who live in the 32 counties of the United States/Mexico border region of Texas.

Services Description

The Health and Safety Code, Section 12.071, established the Office of Border Health (OBH) to "maintain an office in the department to coordinate and promote health and environmental issues between this state and Mexico." OBH field staff in El Paso, Presidio, Eagle Pass, Laredo, and Harlingen work in collaboration with communities and U.S. and Mexican local, state, and federal entities to provide essential public health services. OBH core functions include bi-national communication and coordination (specifically serving as principal agency point of contact to Mexico), inter/intra-agency coordination of border health issues, and clearinghouse for border data and information. OBH works with a wide range of partners in this effort, including the following:

- Eight Texas-Mexico sister-city bi-national health councils;
- U.S.-Mexico Border Health Commission (BHC);
- Border Governors Conference Health Table;
- U.S. Environmental Protection Agency Border 2020 Program;
- Offices of Border Health in Arizona, California, and New Mexico;
- U.S. Department of Health and Human Services (DHHS) Office of Global Affairs; and
- U.S. DHHS Health Resources and Services Administration Office of Border Health.

OBH also coordinates with the BHC's Healthy Border 2020 programs and community-based projects addressing measurable border health objectives.

Immunizations

Target Population

Immunization services improve the health of all Texans.

Services Description

DSHS immunization activities improve quality of life and life expectancy by achieving and maintaining an environment free of vaccine-preventable diseases. Vaccines are a cost-effective public health disease control measure.

DSHS immunization activities seek to increase vaccine coverage levels in both children and adults. In 2012, the immunization coverage level for children 19-35 months was 64.8 percent. DSHS is actively pursuing strategies to increase immunization rates across the state. Key strategies include:

- Promoting use of ImmTrac, the statewide immunization registry used for tracking and reporting vaccines and antivirals and for disaster preparedness purposes;
- Providing education about receiving immunizations in the medical home;

- Encouraging use of reminder/recall systems within the healthcare setting;
- Educating healthcare providers and the public about immunization services and their public health value; and
- Working with stakeholders to improve implementation of these strategies.

Currently, DSHS is embarking on a project to replace the immunization registry in order to meet the emerging challenges of new vaccines, health information exchange, meaningful use guidelines, and a growing population.

Human Immunodeficiency Virus and Sexually Transmitted Disease Services

Target Population

While activities focus on persons living with or at risk of acquiring HIV and other STDs, the program benefits all Texans in its focus on disease prevention.

Services Description

The mission of the HIV/STD Program is to reduce new HIV and STD infections and assure access to treatment and care for those infected by significantly reducing the number of persons with undiagnosed or untreated infections. The program's strategic approach emphasizes coordinated and comprehensive actions at the individual level by offering treatment or testing services, and by making changes in environments and systems that interact with individuals. Efforts focus on the groups and communities most at risk or with the greatest burden of undiagnosed or untreated infection.

Desired outcomes include decreasing the number of persons with late diagnosis, increasing participation in treatment, increasing community urgency and awareness, and supporting integrated and focused prevention programs. Strategies include creating cross-agency and community-based partnerships, developing strategic communications, enhancing the collection and application of surveillance data and program information, and focusing resources to promote effective and integrated responses. HIV/STD Program activities include:

- Providing HIV/STD surveillance and prevention services;
- Delivering medical and support services for persons living with human immunodeficiency virus infection / acquired immunodeficiency syndrome (HIV/AIDS), including HIV medications for low-income individuals; and
- Providing notification and testing services for partners of individuals diagnosed with HIV/STD.

HIV Surveillance

The DSHS HIV/STD Program surveillance system collects and verifies disease reporting data from local sites across Texas. These data are used to inform the public about the extent of HIV and STD infection, guide HIV and STD prevention efforts, allocate resources, and inform the disease prevention decisions made by DSHS and other Texas programs. Surveillance data are used for funding, research, and policy decisions in academia and government settings.

HIV/STD Prevention

DSHS HIV/STD prevention efforts include promotion of HIV and STD testing, including routine and targeted testing; focused evidence-based behavioral interventions; and partner services. Services also focus on enhancing linkage to HIV and STD medical treatment for individuals who are newly diagnosed with these infections.

DSHS supports routine HIV testing at several Texas emergency departments, urgent care clinics, correctional health facilities, community health centers (including primary care and family medicine), and family planning and teen health clinics. Targeted testing programs focus on populations most at risk for HIV infection. DSHS funds 24 partner agencies, including local health departments, community-based organizations, and universities. These programs provide participants with the skills and knowledge necessary to prevent HIV transmission. DSHS also places great emphasis on the timeliness and effectiveness of partner services delivery in Texas, also known as contact tracing. Trained disease intervention specialists perform partner services for individuals diagnosed with HIV and other STDs. These services include partner identification, partner notification, counseling, referral for treatment, and case management activities. Ten local health departments and seven DSHS health service regions conduct partner services.

HIV Care and Treatment

The program allocates funds to local communities to provide medical and social support services for persons living with HIV and acquired immune deficiency syndrome (AIDS). The program operates the Texas HIV Medication Program, which provides life-extending and life-saving medications to low-income Texans who are uninsured or underinsured. In 2013, 35,254 HIV-infected Texans received HIV-related medical and social support services from providers supported with state and federal Ryan White Program funds. The Texas HIV Medication Program provided 18,304 clients with 381,340 prescriptions in fiscal year 2013.

Environmental and Injury Epidemiology and Toxicology

Target Population

The Environmental and Injury Epidemiology and Toxicology (EIET) Unit serves the entire Texas population.

Services Description

The EIET Unit uses the principles of epidemiology, toxicology, and surveillance to identify populations at risk and develop evidence-based actions to protect and promote the health of the people of Texas. The unit also provides epidemiological technical assistance to the poison control center network to support real-time disease detection and public health emergency preparedness.

The Child Lead Poisoning Prevention Program collects information on all blood lead reports in Texas and works toward the elimination of childhood lead poisoning in the state through outreach, education, surveillance, and environmental action. In 2012, the program received 73,626 child blood lead reports representing information for 402,571 individual children. There were 1,022 children confirmed to have an elevated blood level. Many were referred for case management, and 913 qualified for an environmental lead investigation.

The Exposure Assessment, Surveillance, and Toxicology Group investigates potential exposures to hazardous substances and the effects they may have on humans and their quality of life. In fiscal year 2012, this group conducted public health assessments at 16 sites potentially affecting 239,457 people.

DSHS maintains a trauma data collection and analysis system for cases, including traumatic brain injuries, spinal cord injuries, major trauma, and drowning/near-drowning. The Texas Emergency Medical Services (EMS)/Trauma Registry also collects, analyzes, and disseminates information on EMS runs and the occurrence of trauma injuries in Texas. Examples include traffic, residential, recreational, and occupational injuries and injuries due to violence, abuse, suicide, and firearms. These data are used to generate public information campaigns to reduce injuries to Texans, allocate EMS funds, help determine uncompensated care funds, and develop hospital system development grants. In 2012, the EMS/Trauma Registry processed 2,622,927 reports representing 2,490,063 individual records.

The EIET Unit includes the child lead poisoning prevention program; the exposure, assessment, surveillance and toxicology group; and the injury and EMS/Trauma Registry group. The unit also provides epidemiological technical assistance to the poison control center network to support real-time disease detection and public health emergency preparedness.

Zoonosis Control

Target Population

Zoonoses are diseases transmissible from animals to humans. Program activities include monitoring and responding to zoonotic diseases. These activities benefit the entire Texas population.

Services Description

Zoonosis Control protects the public's health through prevention and control of diseases transmitted between animals and humans, such as plague, West Nile virus, rabies, Lyme disease, anthrax, brucellosis, malaria, and tularemia. Key services include:

- Distributing oral rabies vaccine baits in targeted areas of the state to control rabies in certain wildlife species and thereby reducing exposure of people and domestic animals to rabies (approximately 11.2 million vaccine baits to be distributed during 2015–2019);
- Providing technical assistance to the medical and veterinary medical communities and the public;
- Developing and making available public educational materials and conducting zoonotic disease awareness outreach programs;
- Mobilizing community efforts, such as pet neutering programs statewide through Animal Friendly grants, which are supported by the purchase of specialty license plates; and
- Collaborating and coordinating with federal and state animal health agencies to protect public health.

Infectious Disease Control

Target Population

Infectious disease control functions serve the entire Texas population.

Services Description

Infectious disease activities are essential in improving the public health response to disasters or disease outbreaks. Key functions that support epidemiological and surveillance activities include:

- Monitoring and tracking more than 45 reportable infectious diseases in order to detect significant changes in disease patterns that might indicate a new common exposure or a bioterrorism event;

- Informing and advising the public, the medical community, and local and regional health departments on disease control measures to reduce serious illness and death;
- Supporting, collaborating, and providing technical assistance to local and regional health departments on appropriate methods to monitor diseases, investigate disease outbreaks, and conduct studies to identify newly emerging infectious diseases and their risk factors; and
- Developing and implementing systems to monitor healthcare-associated infections and preventable adverse events to assess the magnitude of infections and events in populations and improve healthcare quality.

Tuberculosis Services

Target Population

Tuberculosis (TB) prevention and control activities serve the entire Texas population.

Services Description

TB-related activities include the following:

- Providing TB disease surveillance,
- Supporting TB prevention and control activities in DSHS health service regions and local health departments,
- Providing TB testing supplies and medications, and
- Regulating screening and treatment for active and latent TB infection (LTBI) in certain county jails and other correctional facilities.

Surveillance

State law mandates the reporting of confirmed and suspected cases of TB, as well as contacts to known cases and persons identified with LTBI. Reports are made to the local health authority. DSHS maintains the TB surveillance database and reports TB cases to the Centers for Disease Control and Prevention (CDC) as required. The surveillance system serves as a statewide registry of TB cases and their contacts. Information from the system is a critical tool for program planning purposes, contact investigations, and outbreak investigations. The TB Program also maintains a specialized registry of drug-resistant TB cases reported to the state to ensure appropriate follow up and treatment. Over the past decade, TB cases have declined by approximately seven percent in Texas.

Prevention and Control

The TB Program provides guidance and support to health service regions and local health departments on how to conduct targeted testing, contact investigations, and

outbreak investigations. DSHS works with partners and community-based organizations to establish TB screening programs and to target high-risk populations in areas with a high TB prevalence. In addition, the program oversees four bi-national projects that provide specialized assistance in prevention and control activities in the Texas-Mexico border regions where the prevalence of TB is high.

Testing Supplies and Medications

The TB Program provides testing supplies used by regional and local health department TB screening and testing programs. Additionally, DSHS provides medications recommended for treatment of TB and LTBI to the regional and local TB clinics throughout the state.

County Jails

DSHS regulates the screening and treatment for active TB and LTBI in certain county jails and other correctional facilities. DSHS is charged with reviewing and approving local jail standards related to TB screening tests of employees, volunteers, and inmates. The TB Program provides technical assistance and consultation to these correctional facilities as needed.

Health Care Provider Education/Consultation

The CDC-funded Heartland National TB Center (HNTC), in San Antonio, provides TB consultant services at no cost to healthcare providers and local health departments statewide. HNTC also develops and implements integrated and specialized curricula for professional training and education in all facets of TB elimination, treatment, case management, and testing strategies.

Health Promotion and Chronic Disease Prevention

Target Population

Health promotion and chronic disease programs benefit the entire Texas population.

Services Description

Individual, community, environmental, and system-level evidence-based changes promote healthier decisions and healthier communities and prevent chronic disease. Targeted chronic diseases include cardiovascular disease (CVD), cancer, diabetes, obesity, Alzheimer's disease, asthma, and arthritis. DSHS engages in the following activities to educate individuals on healthy life choices, engage communities, and increase access to clinical preventive services:

- Chronic disease surveillance and evaluation,
- Local and community leadership and policy development,

- Health care systems improvement,
- Evidence-based interventions to create and support healthy environments that improve access to healthy foods and safe places for physical activity,
- Evidence-based interventions that promote healthy eating and active living,
- Promotion of worksite wellness, and
- Health education and community outreach.

Cardiovascular Disease and Stroke Program

Target Population

The CVD and Stroke Program targets individuals who have or who are at risk for developing CVD and stroke. The program also targets healthcare professionals.

Services Description

The goals of the CVD and Stroke Program are to prevent CVD and stroke and reduce the risk factors such as hypertension and cholesterol.

The CVD and Stroke Program works to achieve these goals through the following activities:

- Providing technical assistance, training, and consultation on the development of strategies to decrease risk factors for heart disease and stroke and increase chances for people in Texas to establish a heart and stroke healthy lifestyle;
- Working through multiple sectors to implement strategies that support and reinforce healthy behavior, community-clinical linkages, health systems interventions (including quality improvement activities), and surveillance and epidemiology;
- Providing education and resources to internal and external stakeholders on various topics related to CVD and stroke, such as clinic systems, accountability measures, and professional tools and guidelines on high blood pressure; and
- Providing administrative support to the Texas Council on Cardiovascular Disease and Stroke and the Texas Cardiovascular Disease and Stroke Partnership.

Texas Comprehensive Cancer Control Program

Target Population

Texas Comprehensive Cancer Control Program (TCCCP) has a statewide reach with a focus on high-burden cancers in underserved areas of Texas.

Services Description

The goals of the TCCCP include:

- Routinely supporting, collaborating with, and coordinating with the Cancer Alliance of Texas (CAT) to strengthen the capacity for Texas Cancer Plan implementation;
- Increasing capacity of local cancer stakeholders to implement the Texas Cancer Plan;
- Decreasing the percent of adults who report smoking cigarettes or using smokeless tobacco on one or more of the previous 30 days;
- Increasing the percent of women who receive breast cancer screening according to national guidelines to detect breast cancer early;
- Increasing the percent of cancer survivors who report an increased quality of life after receiving navigation;
- Increasing the percent of adult cancer survivors who receive a written summary of their cancer treatments;
- Decreasing the percent of cancer survivors reporting five or more physically unhealthy days during the past 30 days; and
- Routinely monitoring cancer burden data to support and guide selected program activities and measure success.

To achieve these goals, the TCCCP implements a multi-pronged approach that includes the following:

- Working collaboratively with CAT to advance cooperative efforts that focus on cancer prevention, early detection, screening, and other related or supportive efforts among the population of Texas;
- Supporting community-based Texas Cancer Plan projects that implement evidence-based cancer control initiatives; and
- Promoting, enhancing, and expanding public and private partners' efforts to implement the Texas Cancer Plan.

Alzheimer’s Disease Program

Target Population

The Alzheimer’s Disease Program was established in 1987 to provide information and support to persons with Alzheimer’s disease (AD), their families and caregivers, and healthcare practitioners.

Services Description

The Alzheimer's Disease Program, along with its 12-member legislatively appointed council, has worked to fulfill its legislative purpose of serving as advocates for persons with AD and those who care for them by:

- Coordinating statewide strategic planning to address the burden of AD in Texas;
- Recommending needed action for the benefit of persons with AD and their caregivers;
- Disseminating information on services and related activities for persons with AD to medical and academic communities, caregivers, aging associations, and the general public;
- Promoting coordinated services and activities of state agencies, aging associations, and service providers; and
- Actively serving on aging-related committees and workgroups.

Texas Asthma Control Program

Target Population

In collaboration with other state organizations and community partners, the Texas Asthma Control Program (TACP) strives to improve the quality of life for all Texans living with asthma.

Services Description

The goals of the TACP include:

- Reducing the severity of asthma symptoms,
- Decreasing preventable asthma morbidity,
- Decreasing the number of emergency department hospital visits and deaths due to asthma in Texas, and
- Improving the quality of life for Texans living with asthma.

To achieve these goals, the TACP implements a multi-faceted approach that includes the following:

- Conducting asthma surveillance,
- Supporting and promoting state and local partnerships,
- Promoting policies that address and improve asthma outcomes,
- Funding effective interventions that increase asthma self-management and reduce the burden of asthma in Texas, and
- Evaluating activities to guide the use of program resources and interventions.

Texas Kidney Disease Education Program

Target Population

The Texas Kidney Disease Education Program targets at-risk individuals and healthcare providers in Texas.

Services Description

The service area for this program is the state, with some activities intended to reach specific high-risk areas. The program utilizes public education efforts through a multi-media campaign to urge at-risk individuals to be tested for kidney disease and to inform the public about kidney health. The campaign website is www.lovekidneys.com. The program also targets at-risk individuals through television, cable, and radio public service announcements and radio reads in targeted media markets. The program is in the process of forming a statewide partnership to develop a state plan, which will define activities and target markets.

Diabetes Prevention and Control

Target Population

The Texas Diabetes Program targets persons with diabetes, persons with pre-diabetes, and persons at high risk for developing diabetes.

Services Description

The goals of the Texas Diabetes Program include:

- Preventing type 2 diabetes;
- Preventing or delaying the onset of type 2 diabetes in persons with pre-diabetes, gestational diabetes, and/or other high risks;
- Preventing or delaying complications in persons with diabetes; and
- Assisting persons with diabetes in managing their disease and its complications.

To achieve these goals, the Diabetes Program implements a multi-faceted approach, which includes:

- Community systems changes through local projects that promote safe physical activity and healthful nutrition, and provide local resources for diabetes education for persons with diabetes and healthcare providers;
- Worksite interventions to promote wellness among employees to develop a healthier, supportive work environment;
- Contact with the media to promote lifestyle change messages, prevent onset of diabetes and its complications, and provide links to local resources;

- School-based interventions to ensure implementation of coordinated school health and diabetes care in schools; and
- Healthcare systems changes to promote quality care and prevention efforts for providers, payers, and educators.

Community and Worksite Wellness Program

Target Population

The Community and Worksite Wellness Program targets both general and special populations in communities throughout the state to prevent and reduce obesity and the burden of related diseases and disorders.

Services Description

The program works to reduce the burden of death and disease related to obesity in Texas. The program monitors the nutrition and physical activity status of Texans to identify emerging problems; provides leadership and expertise to state-level stakeholders, partners, and groups; and provides training and technical assistance to communities and worksites to facilitate policy and environmental change strategies to reduce obesity and related chronic diseases. Specific activities include:

- Development and oversight of the Strategic Plan for the Prevention of Obesity in Texas;
- Statewide training to increase capacity for implementing evidence-based policy and environmental change activities;
- Oversight of the Statewide Wellness Program for Texas State Agencies;
- Training and support for liaisons responsible for implementing wellness and health promotion strategies in worksites statewide;
- Oversight of CDC- and state-funded community interventions;
- Training, guidance, and support of staff in regional and local health departments to implement activities related to policy, systems, and environmental change in communities to prevent and control obesity; and
- Promoting collaboration and referral to employee assistance programs for supports, including stress management and behavioral health issues.

School Health Program

Target Population

The School Health Program targets school-age children, parents, and school personnel.

Services Description

The School Health Program functions as a resource for schools and communities to:

- Assist schools in locating and promoting resources and materials on a variety of health topics;
- Serve as a central coordinating point for school health issues, including school nursing practice; and
- Assist school districts in developing an integrated, coordinated approach to school health programming by providing training and technical assistance.

Additionally, the program supports two school health components: school-based health centers that provide campus-based preventive and primary healthcare services and the Texas School Health Advisory Council. The council is a group of individuals from the community appointed by the school districts to provide advice on coordinated school health programming and its impact on student health and learning. The program also develops tools and resources for use by local school districts, including guidance documents related to school health advisory councils, coordinated school health, school health services, and children with food allergies that are at risk for anaphylaxis.

The School Health Program promotes the Centers for Disease Control and Prevention's eight component model of school health, which includes counseling, psychological, and social services. Professionals such as certified school counselors, psychologists, and social workers provide services, including individual and group assessments, interventions, and referrals. Additionally, the School Health Program promotes the Texas School Health Advisory Committee's "Whole Child Approach," which focuses on physical and behavioral health issues in children to help them be ready to learn.

Safe Riders Traffic Safety Program

Target Population

The Safe Riders traffic safety program serves low-income families with children younger than age 14 throughout the state.

Services Description

Safe Riders, funded by the Texas Department of Transportation, has provided child safety seats to low-income families in Texas since the passage of the state's first seat belt law in 1985. In addition to the distribution of safety seats to low-income families, Safe Riders provides those family members with training and education regarding the proper installation of safety seats. Safe Riders also provides Child Passenger Safety (CPS) technician training to nurses, police officers, and community members to be nationally certified as CPS technicians and instructors.

CPS technicians provide parents with hands-on assistance to correctly install and use child safety seats.

Abstinence Education

Target Population

Abstinence education efforts are targeted to adolescents, parents, school personnel, and health professionals.

Services Description

The goal of the Abstinence Education Program is to encourage the implementation of evidence-based interventions that will delay initiation of sexual activity as part of a continuum of services to decrease the rates of teen pregnancy rate and sexually transmitted infections in youth ages 15–19. The program contracts for the provision of in-school and after-school intervention, as well as statewide resources that include:

- Web-based resources for Texas professionals;
- Reference materials for parents;
- Workbooks, brochures, and pamphlets for 5th through 12th grades;
- Training and curricula purchase options for school districts;
- Service learning training workshops open to school districts;
- Teen pregnancy prevention coalitions and conferences; and
- Professional development training.

Children with Special Health Care Needs Services Program

Target Population

The Children with Special Health Care Needs (CSHCN) Services Program serves individuals who meet certain medical and income eligibility. The program pays for healthcare benefits and services not covered by other payers. In addition, the program provides family support services.

Services Description

The CSHCN Services Program supports family-centered, community-based strategies to improve the quality of life for eligible individuals and their families. The program covers healthcare benefits for children with extraordinary medical needs, disabilities, and chronic health conditions and people of any age with cystic fibrosis.

Healthcare benefits include a broad array of medical care and related services. The program contracts with community-based organizations in many parts of the state to

provide case management, family support, community resources, and care coordination. The program also provides case management services through DSHS staff based in eight regional offices. Program staff actively collaborates with consumers, providers, other state agency staff, and interested stakeholders to ensure a system of care is in place to meet the needs of these individuals.

Kidney Health Care Program

Target Population

The Kidney Health Care (KHC) Program serves Texans with end stage renal disease (ESRD) who have incomes of less than $60,000 per year and who are receiving dialysis treatments or have received a kidney transplant.

Services Description

The KHC Program provides medical, drug, Medicare premium payment assistance, and transportation services to persons diagnosed with ESRD. Hospitals, dialysis facilities, and physicians provide medical services (dialysis and access surgery) through contractual agreements. The KHC Program provides payment for covered outpatient drugs and limited reimbursement for travel to receive services. In addition, the program pays monthly premiums for Medicare Parts A, B, and D for eligible Medicare recipients.

Hemophilia Assistance Program

Target Population

The Hemophilia Assistance Program helps people with hemophilia pay for blood factor products.

Services Description

This program provides limited reimbursement to providers for blood derivatives, blood concentrates, and manufactured pharmaceutical products indicated for the treatment of hemophilia and prescribed to eligible clients for use in medical or dental facilities or their homes.

Epilepsy Services Program

Target Population

The Epilepsy Services Program serves Texas residents with seizures and related symptoms who have incomes at or below 200 percent of the federal poverty level and who are not eligible for other programs or services. Individuals younger than

age 21 who are on the waiting list for the CSHCN Services Program can receive services until accepted into the CSHCN Services Program.

Services Description

The Epilepsy Program contracts with nonprofit and governmental entities to provide comprehensive outpatient care, including medical and non-medical services, for persons with epilepsy or seizure disorders.

Services may include diagnosis and treatment of the medical condition; case management system for continuity of care; integration of personal, social, and vocational support services; and public awareness and educational services.

Laboratory Operations

Target Population

The DSHS public health laboratory operations serve all Texans.

Services Description

The DSHS public health laboratory provides analytical, reference, research, training, and educational services related to laboratory testing. Laboratory services include:

- Analytical testing and screening services for children and newborns;
- Diagnostic, reference, and surveillance testing for physicians, hospitals, reference laboratories, and DSHS programs in microbiology;
- Testing to support the investigation of food-borne disease outbreaks and other epidemiological investigations;
- Analytical chemistry testing to support the U.S. Environmental Protection Agency Safe Drinking Water Program and other programs supporting public health environmental programs;
- Chemical threat and bio-threat laboratory testing and training as part of the Preparedness Laboratory Response Network;
- Milk testing;
- Resources for the education and training of laboratory professionals; and
- Quality assurance and oversight.

Approximately 1.3 million specimens and samples are processed per year, including screening 760,000 newborn blood spots for 29 disorders; testing 261,000 specimens as part of the Texas Health Steps program; testing 171,000 microbiological specimens for bacteria associated with communicable diseases, food-borne outbreaks, tuberculosis, influenza, other viruses, and rabies; and analyzing 31,000 drinking water samples.

9.5.2 DSHS Goal 2: Community Health Services

Goal 2 programs seek to ensure that Texans have access to the most fundamental health services, prevention, and treatment across the state, through contracts with providers. Those services include primary healthcare, mental healthcare, and substance abuse services. Under this goal, DSHS also works through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to ensure that good nutrition is accessible to pregnant women, new mothers, and young children. Finally, DSHS works to build healthcare capacity in communities by providing technical assistance and limited funding to organizations applying for certification as emergency medical service providers and state trauma centers.

Special Supplemental Nutrition Program for Women, Infants, and Children

Target Population

The WIC Program provides services to a caseload of an average of 950,000 pregnant, breastfeeding, and post-partum women, and children from birth up to age five who meet income and other eligibility requirements.

Services Description

DSHS administers the WIC Program primarily through contracts with local health departments, cities, counties, hospital districts, hospitals, community action agencies, and other non-profit entities. Women, infants, and children participating in the WIC Program receive nutrition education, breastfeeding support, referrals to healthcare providers, and nutritious supplemental foods. The WIC nutrition services are intended to be an adjunct to good health care during the critical times of a child's early growth and development to prevent health problems and to improve consumers' health status.

The WIC Program strives to achieve a positive change in dietary habits that will continue after participation in the program has ceased. The WIC food package is aligned with the Dietary Guidelines for Americans and the current infant feeding practice guidelines of the American Academy of Pediatrics. Food items issued include: whole grains; fruits and vegetables; and limited amounts of milk, eggs, cheese, and juice.

The WIC Program provides food benefits utilizing electronic benefits transfer (EBT). The WIC EBT card, known as the smart card, is physically similar to a credit card and is accepted by all WIC vendors. The Texas WIC Program has over 560,000 active cards in circulation and processes an average of over $2.2 million in claims daily from over 2,100 vendor outlets.

Women's Health Programs and Services

Family Planning

Target Population

The Family Planning Program serves women of child-bearing age and men who have incomes at or below 250 percent of the federal poverty level (FPL), are Texas residents, and are not eligible to receive the same services through other programs such as Medicaid or the Texas Women's Health Program.

Services Description

The purpose of the program is to provide family planning services, improve health status, and positively affect future pregnancy outcomes. The program also funds special projects across the state for the integration of male services and routine screening for human immunodeficiency virus in family planning clinic settings.

Services include client education, medical history, physical assessment, laboratory testing (including Pap tests), screening for diabetes and anemia, contraception, sexually transmitted infection treatment, referrals for prenatal care, and behavioral health services if needed. Contractors represent a range of healthcare entities, including local health departments, hospital districts, non-profit organizations, and university-based clinics.

Expanded Primary Health Care

Target Population

The Expanded Primary Health Care (EPHC) program serves women ages 18 and older who are Texas residents at or below 200 percent of FPL, and who are not eligible for other programs that provide the same services.

Services Description

The EPHC Program services include six priority diagnosis and treatment services as follows: emergency care; family planning; preventive health, including immunizations; health education; laboratory, X-ray, and nuclear medicine; or other appropriate diagnostic services. Other services may include nutrition, health screening, home health care, dental care, transportation, prescription drugs and devices, durable supplies, environmental health, podiatry, and social services. EPHC has a focus on family planning, breast and cervical cancer services, prenatal services, and prenatal dental services, in addition to other preventive and primary care services.

Breast and Cervical Cancer

Target Population

This program serves women ages 18–64 who are at or below 200 percent of FPL and meet other eligibility requirements. Priority is given to women ages 50–64 for breast cancer screenings and women ages 21–64 who have never been screened or have not been screened in the past five years for cervical cancer.

Services Description

DSHS administers Breast and Cervical Cancer Control activities intended to reduce breast and cervical cancer mortality. The program ensures statewide delivery of breast and cervical cancer screening, diagnostic services, case management, and surveillance services. DSHS contractors provide a variety of services, including clinical breast examinations, mammograms, Pap tests, pelvic examinations, and diagnostic and case management services for women with abnormal test results. Contractors include local and regional health departments, community health centers, federally qualified health centers, public hospitals, and other community-based organizations. Contractors are responsible for assisting women diagnosed with breast or cervical cancer who are potentially eligible for Medicaid for Breast and Cervical Cancer assistance.

Title V, Maternal and Child Health Block Grant

Target Population

Title V-funded direct care programs serve women and their families at or below 185 percent of the FPL who are not eligible for Medicaid or the Children's Health Insurance Program. In addition, Title V Block Grant funds are used to improve the health of mothers, children, and their families through population-based services.

Services Description

The Texas Title V Program provides funds for a wide range of activities supporting preventive and primary care services for pregnant women, mothers, infants, children, and adolescents. DSHS contracts with healthcare organizations and professionals across the state to provide family planning, dysplasia detection, prenatal care, well-baby care, laboratory services, and case management to families. Many of the Texas Title V Program's infrastructure-building and population-based activities include a focus on mental health and substance abuse, such as support of child fatality review teams, suicide prevention efforts, and tobacco cessation. Staff works with partners throughout DSHS and with external stakeholders on various behavioral health issues. Additionally, Title V staff works with the Office of the Attorney General, the Texas Association Against Sexual Assault, and other stakeholders to implement and evaluate sexual violence prevention and education efforts in Texas.

Title V also supports population-based services, such as screening Texas children for health needs related to vision and hearing, spinal abnormalities, newborn hearing loss, and newborn diseases. Title V-funded programs also promote adolescent health, car seat safety, breastfeeding, safe sleep for infants, and fluoridation of drinking water supplies across Texas.

In 2010, DSHS initiated efforts to reduce infant mortality through the Healthy Texas Babies initiative with support from various state partners including the HHSC and the Texas Chapter for the March of Dimes. Efforts within this initiative include local coalitions using evidenced-based interventions to address infant mortality factors, provider and public education regarding late pre-term birth and other topics, and a website with the latest state data and links to various resources supporting healthy birth outcomes.

Starting in 2012, DSHS also initiated efforts to reduce maternal mortality and severe maternal morbidity. Based upon implementation of Senate Bill 495 (83-R), DSHS has established the Maternal Mortality and Morbidity Task Force and report findings to the Legislature. This task force is described in Chapter 4 of this document, in Section 4.4.5.

Child and Adolescent Health

Target Population

Child and adolescent health programs in Texas serve low-income children and adolescents, including parents as appropriate, as determined by specific program eligibility requirements.

Services Description

Child and adolescent health services include comprehensive and preventive health care administered through a variety of programs and funding sources. Related activities also include designing and implementing federally mandated outreach materials to educate and train parents, child care providers, and early childhood professionals on health and safety issues.

Newborn Screening

Newborns in Texas are screened for 30 disorders, including hearing loss. Screening for critical congenital heart disease, a point-of care screening, will begin in 2014. The goal of the program is to decrease the morbidity and mortality of infants born in Texas by providing:

- Accurate and high-quality laboratory analysis for practitioners,
- Clinical care coordination services, and
- Outreach education.

Oral Health

The Oral Health Program provides preventive dental services to low-income children of preschool and elementary school age. Services include dental screening exams, topical fluoride application for preschool age-children, and placement of dental sealants for children of elementary school age. The program works collaboratively with Head Start grantees, dental schools, dental hygiene programs, faith-based organizations, community-based organizations, organized dentistry and dental hygiene organizations, and other interested parties to leverage available local resources for the provision of preventive and therapeutic dental services to target populations.

Texas Health Steps

Texas Health Steps (THSteps) is the Early and Periodic Screening, Diagnosis, and Treatment program for Texas children from birth through age 20 who are on Medicaid. THSteps services include regular medical checkups, dental checkups, and treatment. This preventive focus helps to identify and prevent health and dental problems. Ongoing outreach and education efforts build the capacity of communities to deliver healthcare services and provide useful information for service recipients.

Case Management for Children and Pregnant Women

The Case Management for Children and Pregnant Women Program provides services to children with a health condition or health risk, birth through age 20, and to high-risk pregnant women of all ages, in order to encourage the use of cost-effective health and health-related care. Case managers assist children and women who are pregnant, as well as their families, with accessing needed medical services, appropriate educational services, and other identified medically necessary service needs. Enrolled Medicaid providers and DSHS regional case management staff provide direct case management services to assist eligible clients with access to care. The program does not provide educational or clinical services directly.

Personal Care Services

DSHS determines eligibility for Personal Care Services (PCS). Children on Medicaid, from birth through age 20, are eligible for PCS if they have a physical, behavioral, or cognitive condition that limits their activities of daily living. DSHS regional case management staff performs a comprehensive assessment, determines eligibility, authorizes hours of attendant services, and coordinates with home health agencies. DSHS coordinates with the Department of Aging and Disability Services to transition recipients to adult attendant care if needed when they age out of the PCS program.

Genetics Program

The Genetics Program contracts for direct genetic services and population-based genetic projects. Genetics staff educates healthcare providers, consumers, and the public about the benefits of genetic services.

Primary Health Care

Target Population

The Primary Health Care (PHC) program serves Texas residents at or below 200 percent of the FPL who are not eligible for other programs that provide the same services.

Services Description

The PHC Program services include six priority diagnosis and treatment services: emergency care; family planning; preventive health, including immunizations; health education; laboratory, X-ray, and nuclear medicine; or other appropriate diagnostic services. Other services may include nutrition, health screening, home health care, dental care, transportation, prescription drugs and devices, durable supplies, environmental health, podiatry, and social services. On an annual basis, contractors establish local service delivery plans targeting their communities' priority health issues based on needs assessment findings and input from advisory committees.

County Indigent Health Care Program

Target Population

The County Indigent Health Care Program serves Texas residents with income at or below 21 percent of the FPL who are not categorically eligible for Medicaid.

Services Description

The program is locally administered by counties, public hospitals, and hospital districts, with program oversight assigned to DSHS. Program staff assists counties in meeting their statutory indigent healthcare responsibilities by providing technical assistance and state funding for a portion of the counties' indigent healthcare costs.

Community Behavioral Health Services for Adults and Children

Community Mental Health Centers

Target Population

The adult mental health priority population consists of adults who have severe and persistent mental illnesses (diagnoses of schizophrenia, bipolar disorder, or major depressive disorder) and significant functional impairment. The priority population also includes persons who require crisis assessment and/or stabilization. The children's mental health priority population is children ages 3–17 who have a diagnosis of mental illness and who:

- Have a serious functional impairment,
- Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms, or
- Are enrolled in special education because of a serious emotional disturbance.

Texas Resilience and Recovery (TRR) is an organized and accountable system of care to increase access to evidence-based practices within a standard framework across the state. Those who are not prioritized for ongoing TRR services may be eligible for crisis services and/or short-term transition services.

Service Description

As the state mental health authority, DSHS manages contracts with 38 community mental health centers across Texas. Through these contracts, TRR is the approach used to direct evidence-based services and supports to recipients. TRR is intended to provide treatment in sufficient amounts to facilitate recovery. Available services for adults include supported employment, permanent supportive housing, cognitive behavioral therapy, illness management and recovery, assertive community treatment, medication management, psychosocial rehabilitation, and case management. Available services for children include skills training, counseling, cognitive behavioral therapy, certified family partners, medication management, wraparound services, and case management.

NorthSTAR

Target Population

NorthSTAR services are for Medicaid-eligible and other individuals who meet eligibility criteria for community mental health or substance abuse services, and who reside in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties.

Services Description

NorthSTAR is an integrated behavioral health project that blends funding (Medicaid, mental health and substance abuse block grant funds, and state general revenue)

from HHSC and DSHS to provide managed behavioral healthcare (mental health and substance abuse) services.

Substance Abuse Services

Target Population

Substance abuse prevention services are available to children, youth, and adult populations. Substance abuse treatment services are available to youth and adults identified as having or showing signs of a substance abuse problem. Treatment services are available to persons who meet the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, criteria for substance use disorders and who are medically indigent. In addition, state and federal law specifies priority risk groups, including identified substance abusers infected with human immunodeficiency virus (HIV) and persons at risk for HIV, persons who use intravenous drugs, and women with substance use disorders who are pregnant and/or parenting or have had their children removed from the home because of a substance use disorder.

Services Description

As the state substance abuse authority, DSHS has developed a service continuum to address substance use and abuse. Services are delivered through community organizations that contract with the state. The service continuum ranges from universal prevention to treatment.

Prevention services are delivered using a comprehensive program design that includes the Institute of Medicine's universal, selective, and indicated prevention classifications. Community coalitions deliver evidence-based approaches through environmental strategies designed to change behavior, attitudes, and policy. Eleven prevention resource centers are located throughout the state and are the regional repositories for data collection. They coordinate various data elements with the regional community coalitions, universities, hospitals, and provider networks. The data that is collected allows entities located within the region to prioritize the need for services.

Outreach, Screening, Assessment, and Referral services identify persons with substance abuse problems, evaluate their needs and preferences, and link them with appropriate treatment and support services. These services are provided in conjunction with focused, short-term interventions to motivate and prepare individuals for treatment or self-directed change in behavior when more intensive treatment is not indicated.

Treatment services for adults and youth are provided in residential and outpatient settings. Services include individual and group counseling, life skills, and substance abuse education. In 2014, recovery supports are being added to the continuum of services offered during and post treatment.

Approximately 84 percent of Texas' funding for substance abuse services in fiscal year 2013 was provided by federal block grant funds, which include the federal requirements for priority risk populations noted earlier.

Tobacco Prevention and Control

Target Population

Tobacco prevention and control efforts benefit all Texans.

Services Description

The mission of the DSHS Tobacco Prevention and Control Program is to reduce the health effects and economic toll of tobacco. The goals of the program include:

- Preventing tobacco use among young people;
- Promoting compliance and supporting adequate enforcement of federal, state, and local tobacco laws;
- Increasing cessation among young people and adults;
- Eliminating exposure to secondhand smoke;
- Reducing tobacco use among populations with the highest burden of tobacco-related health disparities; and
- Developing and maintaining statewide capacity for comprehensive tobacco prevention and control.

DSHS implements a variety of initiatives to prevent tobacco use and initiation and to emphasize enforcement of state and federal laws limiting youth access to tobacco. These include public awareness campaigns and youth outreach initiatives to support program goals for preventing tobacco use, increasing cessation, and reducing exposure to secondhand smoke. Additionally, DSHS is partnering with the State Comptroller of Public Accounts and Texas State University in San Marcos to continue state efforts to enforce state tobacco laws. DSHS also partners with the U.S. Food and Drug Administration to enforce federal tobacco laws dealing with underage sales of tobacco. To assist tobacco users to quit, cessation counseling services are available statewide.

Nine local community organizations serving twelve coalitions are funded to implement comprehensive tobacco prevention and control strategies proven to be effective to reach the program goals and reduce tobacco use in Texas. The coalitions conduct needs assessments regarding community tobacco use and tobacco-related health consequences; build local capacity to address those needs; and plan, implement, and evaluate comprehensive evidence-based tobacco prevention and control strategies to address tobacco use among adults and youth. The grant funds are awarded to coalitions serving in Wichita, Red River, Lamar,

Rusk, Angelina, Nacogdoches, Galveston, Brazos, Nueces, Ellis, Walter, and Hidalgo counties.

Community Capacity Building

Target Population

Community capacity building programs benefit all Texans.

Service Description

DSHS provides a variety of services to develop and enhance the capacities of community clinical service providers and regiona.

Recruitment and Retention of Health Professionals

The Texas Primary Health Care Office oversees cooperative agreement funding from the U.S. Department of Health and Human Services, Health Resources and Services Administration. This funding provides support for recruitment and retention of health professionals across the state. The program focuses on clinics that are located in health professional shortage areas and medically underserved areas. The federal funds also support activities that measure access to healthcare services and designate provider shortage areas and medically underserved communities.

The Texas Conrad 30 program, which places foreign physicians in medically underserved areas, helps communities develop the capacity to provide medical services to their citizens.

Emergency Medical Services (EMS) and Trauma Systems Capacity Building

DSHS builds community capacity to ensure the public's safety through EMS/trauma systems across the state. To ensure the availability of prompt and skilled emergency medical care, a network of regional EMS/trauma systems coordinates their work to decrease mortality and improve the quality of emergency medical care. Emergency medical care is enhanced through the administration of grant programs targeting EMS providers, regional advisory councils, and hospitals.

9.5.3 DSHS Goal 3: Hospital Facilities and Services

Goal 3 covers those direct services, mostly inpatient, that DSHS provides at state-administered facilities. These include mental health care provided at nine state hospitals and the Waco Center for Youth (WCY), care for individuals with tuberculosis (TB) and Hansen's disease at the Texas Center for Infectious Disease, and primary health care at the Rio Grande State Center Outpatient Clinic.

State Mental Health Hospitals

Target Population

The State Mental Health Hospitals (SMHHs) admit individuals who have a mental illness and either present a substantial risk of serious harm to self or others, or show a substantial risk of mental or physical deterioration. Special populations served include the following: children and adolescents, adults, geriatrics, physically aggressive patients, persons with co-occurring psychiatric and substance abuse disorders, persons found not guilty by reason of insanity, and persons requiring competency restoration services.

The WCY admits children ages 13-17 who have a diagnosis of being emotionally disturbed, who have a history of behavior adjustment problems, and who need a structured treatment program in a residential facility.

Service Description

The SMHH system includes nine state hospitals and the WCY. The primary role of the SMHH system is to provide inpatient services to persons with serious mental illnesses whose needs are not being met in a community setting.

SMHHs provide specialized and intensive inpatient services. Local mental health authorities jointly plan services in each hospital's service area with the SMHH. Services are based on local conditions and factors, including the number of admissions and type of services to be provided. A seamless interaction of hospital-based and community-based services is promoted through coordination, collaboration, and communication.

Rio Grande State Center Outpatient Clinic

Target Population

The Rio Grande State Center (RGSC) Outpatient Clinic provides outpatient medical care and radiology and lab services primarily to indigent adult residents throughout a four-county service area (Cameron, Hidalgo, Willacy, and Starr counties). The South Texas Public Health Laboratory on the campus of RGSC serves the outpatient clinic laboratory needs and the public health needs for medical emergencies and bioterrorism response for health service region 11.

Service Description

RGSC Outpatient Clinic provides primary health care services including:

- Outpatient primary care/internal medicine clinic,
- Pharmacy and patient drug assistance program,

- Cancer screening and detection,
- Women's health clinic (bone density testing and sexually transmitted disease screening),
- Medical nutrition therapy and diabetes education, and
- Diagnostic radiology and lab services.

Texas Center for Infectious Disease

Target Population

Texas Center for Infectious Disease (TCID) serves patients older than age 16 who have a diagnosis of TB or Hansen's disease (leprosy) who require hospitalization or specialized services. Patients are referred by local health departments, private providers, and local courts managing patients with infectious TB and Hansen's disease, as well as by other states with an interstate compact with Texas.

Service Description

TCID provides quality medical care for patients with TB, Hansen's disease, and other related infectious diseases. TCID provides inpatient services for patients requiring long lengths of stay to complete treatment. For surgical services, intensive care, sophisticated diagnostics, advanced therapeutics, and emergency care, TCID contracts with the University of Texas Health Science Center at Tyler, the University of Texas Health Science Center at San Antonio, and other San Antonio-area providers. The facility provides outpatient services to treat patients with TB and Hansen's disease, as well as complications and co-morbidities affecting treatment of those diseases.

TB remains a communicable disease with the potential to spread and therefore must be contained. The importance of this effort is made even more serious by the development of drug-resistant and extremely drug-resistant strains. TCID has the capability to respond to acts of bioterrorism and provide first line responders with expertise in communicable disease treatment.

9.5.4 DSHS Goal 4: Consumer Protection Services

Goal 4 programs protect the health of Texans by ensuring high standards in the following areas: healthcare facilities, allied and mental health care, emergency medical services (EMS) providers and personnel, food and food preparation, pharmaceuticals, medical and radiological devices, and consumer products.

Target Population

Regulatory services at DSHS oversee licensing, enforcement, and compliance activities for healthcare facilities, credentialed professionals, and consumer safety products and services that affect the entire permanent and visiting population of Texas.

Service Description

The basic functions of regulatory services include:

- Developing and maintaining licensing standards, within statutory authority, through a stakeholder-inclusive rule development process;
- Reviewing application materials, collecting fees, and issuing licenses;
- Conducting quality assurance surveys, inspections, and complaint investigations; and
- Initiating appropriate enforcement actions to promote compliance.

In fiscal year 2013, the total number of licenses overseen by DSHS exceeded 350,000. In addition, there are a large number of entities that are not state-licensed, over which DSHS provides some inspection and enforcement authority. Also, the Office of EMS/Trauma Systems provides trauma designation levels I-IV and primary and support stroke designation for hospitals. DSHS also has a disaster planning and homeland security role with regulated entities.

The discussion below describes the areas in which DSHS has a regulatory role.

Health Care Professionals

Eleven independent licensing boards are administratively attached to DSHS. These boards regulate the practices of allied and mental health professions, and they adopt and enforce rules. DSHS provides the administrative support for their operations. These independent boards govern the following professionals:

- Speech language pathologists and audiologists,
- Athletic trainers,
- Marriage and family therapists,
- Professional counselors,
- Social workers,
- Fitters and dispensers of hearing instruments,
- Sex offender treatment providers,
- Orthotists and prosthetists,
- Dietitians,

- Midwives, and
- Medical physicists.

DSHS governs other professionals and licensing programs that include:

- Medical radiologic technologists and associated training programs,
- Respiratory care practitioners,
- Massage therapists and associated establishments and training programs,
- Perfusionists,
- Chemical dependency counselors and associated training entities,
- Code enforcement officers,
- Contact lens dispensers,
- Emergency medical services personnel and associated firms,
- Offender education programs and instructors,
- Opticians,
- Personal emergency response system providers,
- Sanitarians, and
- Dyslexia therapists and practitioners.

The licensing process for healthcare professionals includes reviews of transcripts of educational courses/programs to determine applicant fitness for each field of practice. A critical part of the eligibility requirement for most of the professions is the passing of a competency examination, developed either by DSHS or through a nationally recognized examination provided by a national examination vendor. DSHS also performs criminal history background checks on applicants and licensees to ensure initial and continued eligibility, and audits continuing education records to review the types of courses offered and to ensure licensee compliance. DSHS receives and investigates consumer complaints against regulated professions and imposes disciplinary action against licensees when violations are substantiated.

Within this licensing function, DSHS also approves/certifies and monitors offender education programs and program instructors. The four mandated courses are Driving While Intoxicated (DWI) Education, DWI Intervention, Alcohol Education Program for Minors, and Drug Offender Education. Each program must utilize DSHS-approved curricula and offer administrator/instructor training in the delivery of the services. DSHS administers the training, approval, and monitoring of instructors for the Texas Youth Tobacco Awareness Program to ensure that Texas youth are able to complete a tobacco awareness course. The program implements the Texas Adolescent Tobacco Use and Cessation curriculum.

Health Care Facilities

DSHS regulates approximately 2,600 health care facilities, including:

- Hospitals,
- Birthing centers,
- Ambulatory surgery centers,
- End stage renal disease facilities,
- Free-standing emergency medical care facilities,
- Special care facilities,
- Abortion facilities,
- Substance abuse facilities,
- Narcotic treatment facilities,
- Crisis stabilization units, and
- Private psychiatric hospitals.

DSHS conducts: Medicare certification-related activities for rural health clinics, portable X-ray services, outpatient physical therapy, and comprehensive outpatient rehabilitation services. DSHS is a contractor with the Centers for Medicare and Medicaid Services for the Clinical Laboratory Improvements Amendments Program, which regulates all laboratory testing (except research), performed on humans.

Food (Meat) and Drug Safety

Food and drug products are regulated to prevent the sale and distribution of contaminated, adulterated, and mislabeled foods and drugs. This includes retail food establishments, food and drug manufacturers, wholesale food and drug distributors, food and drug salvagers, meat and poultry processors and slaughterers, milk and dairy food processors, and molluscan shellfish processors and shippers. Newly emerging pathogens and food-borne illness outbreaks associated with food items previously believed to be comparatively safe require DSHS to look at new and different methods of regulation, inspection, and risk management. Additionally, DSHS tests tissue samples from fish, monitors seafood harvesting areas, and certifies Texas bay waters for safety. State regulations and standards are closely tied to those of the U.S. Food and Drug Administration and the U.S. Department of Agriculture to ensure food products are safe and can be sold inside and outside the borders of Texas. For consumer safety, DSHS also regulates:

- Manufacturers and distributors of drugs, cosmetics, and medical devices;
- School cafeterias;
- Tattoo and body piercing studios; and
- Tanning studios.

Environmental Health

Regulation includes the licensing, inspection, and monitoring of asbestos, lead, and mold abatement activities and hazardous chemicals registration. Hazardous consumer products, such as bedding, toys, and abusable volatile chemicals, are regulated to keep Texans safe. Also critical to consumer health and safety are general sanitation services, such as inspections and regulation of public swimming pools and youth camps.

Radiation Control

DSHS protects Texans from the harmful effects of radiation by regulating the possession and use of radioactive materials (including nuclear medicine, industrial radiography, and oil and gas well logging) in a manner that maintains compatibility with the requirements of the 1963 Agreement between Texas and the U.S. Nuclear Regulatory Commission. DSHS also regulates radiation-producing machines, such as X-ray, mammography, and laser hair removal devices and lasers used in medical, industrial, and research facilities, along with technicians and facilities where all the above devices are used. Additionally, DSHS develops radiological emergency response plans and conducts full scale exercises on those plans at nuclear power plants. The Texas Radiation Advisory Board is an 18-member, Governor-appointed board that provides advice on radiation rules and state radiation control policy.

Emergency Medical Services (EMS)/Trauma System

DSHS is responsible for developing, implementing, and evaluating a statewide EMS and trauma care system, including the designation of trauma and stroke facilities. Currently, there are 123 designated stroke facilities and 275 designated trauma facilities in Texas. The Governor's EMS and Trauma Advisory Council advises DSHS on rules and standards for the system. H.B. 15 (83-R) requires DSHS to develop a perinatal level of care designation program with recommendations from the Perinatal Advisory Council, which will advise DSHS on the rules and standards for both neonatal and maternal levels of care. It is anticipated that approximately 250 hospitals will request designation for some level of neonatal and/or maternal care. Additional disease modalities, such as acute cardiac events, may be considered for inclusion in the EMS/trauma system and designation programs in the future.

Medical Advisory Board

The Medical Advisory Board makes professional medical recommendations to the Department of Public Safety regarding the ability of individuals to operate a motor vehicle and/or a handgun safely for approval or denial of relevant licenses.

9.5.5 DSHS Goal 7: Office of Violent Sex Offender Management

This new goal covers duties related to the sexually violent predator civil commitment program. To protect Texas citizens, the Texas Health and Safety Code requires the provision of a civil commitment procedure for the long-term supervision and treatment of sexually violent predators.

On October 1, 2011, this civil commitment responsibility was transferred to the newly created Office of Violent Sex Offender Management, which is administratively attached to DSHS. The Office is responsible for providing appropriate and necessary treatment and supervision through the case management system. The Legislature recognizes that this small but extremely dangerous group of sexually violent predators has a behavioral abnormality, which is not amenable to traditional mental illness treatment modalities and that they are most likely to engage in repeated predatory acts of sexual violence. As of March 2014, 327 sexually violent predators have been civilly committed.

Chapter 10

Goals, Objectives, and Strategies

The following presentation of goals, objectives, and strategies, by agency, reflects the structure in negotiation with the Legislative Budget Board (LBB) and the Governor's Office of Budget, Planning, and Policy (GOBPP) as of June 2014. This structure will later incorporate performance measures and become the framework for the agency's budget.

10.1 Health and Human Services Commission

10.1.1 Goal 1: HHS Enterprise Oversight and Policy

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. 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 Supplemental Nutrition Assistance Program (SNAP) benefits.

Objective 1-2. HHS Consolidated System Support Services. 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.

10.1.2 Goal 2: Medicaid

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. Administer programs that provide medically necessary health care in the most appropriate, accessible, and cost-effective setting.

Strategy 2-1-1. Aged and Medicare-Related Eligibiility Group. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to aged and Medicare-related Medicaid-eligible persons.

Strategy 2-1-2. Disability-Related Eligibility Group. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting for disability-related Medicaid-eligible adults and children.

Strategy 2-1-3. Pregnant Women Eligibility Group. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting for Medicaid-eligible pregnant women.

Strategy 2-1-4. Other Adults Eligibility Group. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to adults who are principally income-level eligible (non-pregnant, non-Medicare, non-disability-related).

Strategy 2-1-5. Children Eligibility Group. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to newborn infants and Medicaid-eligible children who are not receiving SSI disability-related payments.

Objective 2-2. Other Medicaid Services. Provide policy direction and management of the state's Medicaid program and maximize federal dollars.

Strategy 2-2-1. Non-Full Benefit Payments. Provide medically necessary health care to eligible recipients for certain services not

covered under the insured arrangement, including: undocumented persons, school health, women's health, and other related services.

Strategy 2-2-2. Medicaid Prescription Drugs. 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. Health Steps (EPSDT) Dental. Provide dental care in accordance with all federal mandates.

Strategy 2-2-5. Medicare Payments (For Clients Dually Eligible for Medicare and Medicaid). Provide accessible premium-based health services to certain Title XVIII Medicare-eligible recipients.

Strategy 2-2-6. Transformation Payments. Maximize federal funding to provide supplemental Medicaid reimbursement for uncompensated care and delivery system reform incentives under the 1115 waiver.

Objective 2-3. Medicaid Support. Improve the quality of services by serving as the single state Medicaid agency.

Strategy 2-3-1. Medicaid Contracts and Administration. Administer efficient and effective Medicaid program, set the overall policy direction of the state Medicaid program, and manage interagency initiatives to maximize federal dollars.

10.1.3 Goal 3: CHIP Services

Ensure health insurance coverage for eligible children in Texas.

Objective 3-1. CHIP Services. Ensure health insurance coverage for eligible children in Texas.

Strategy 3-1-1. Children's Health Insurance Program (CHIP). Provide health care to uninsured children who apply and are determined eligible for insurance through CHIP.

Strategy 3-1-2. CHIP Perinatal Services. Provide health care to perinates whose mothers apply and are determined eligible for insurance through CHIP.

Strategy 3-1-3. CHIP Prescription Drugs. Provide prescription medication to CHIP-eligible recipients (includes all CHIP programs), as provided by their treating physician.

Strategy 3-1-4. CHIP Contracts and Administration. Administer efficient and effective CHIP program, including contracted administration, and set the overall policy direction of CHIP program.

10.1.4 Goal 4: Encourage Self-Sufficiency

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

Objective 4-1. Assistance Services. Provide appropriate support services that address the employment, financial, and/or social service needs of eligible persons.

Strategy 4-1-1. TANF (Cash Assistance) Grants (Temporary Assistance for Needy Families Grants). Provide Temporary Assistance for Needy Families grants to low-income Texans.

Strategy 4-1-2. Refugee Assistance. Assist refugees in attaining self-sufficiency through financial, medical, and social services, and disseminate information to interested individuals.

Strategy 4-1-3. Disaster Assistance. Provide financial assistance to victims of federally declared natural disasters.

Objective 4-2. Other Family Support Services. 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. Nontransferable. Provide pregnancy support services that promote childbirth for women seeking alternatives to abortion.

Strategy 4.2.3. Texas Women's Health Program. Provide low-income women with family planning services, related health screenings, birth control, and treatment of certain sexually transmitted infections.

10.1.5 Goal 5: Program Support

Objective 5-1. Program Support.

Strategy 5-1-1. Central Program Support.

Strategy 5-1-2. Information Technology Program Support.

Strategy 5-1-3. Regional Program Support.

10.1.6 Goal 6: Information Technology Projects

Objective 6-1. Information Technology Projects.

Strategy 6-1-1. TIERS and Eligibility Technologies (Texas Integrated Eligibility Redesign System & Supporting Tech). Texas Integrated Eligibility Redesign System and eligibility supporting technologies capital.

10.1.7 Goal 7: Office of Inspector General

Objective 7-1. Client and Provider Accountability. 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.

10.2 Department of Aging and Disability Services

10.2.1 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 Authorities (LAs).

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). 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/IID.

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. 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. ID 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.

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—ID. Provide residential services and supports for individuals with intellectual and developmental disabilities living in intermediate care facilities for persons with ID (ICFs/IID).

Strategy 1-7-1. Intermediate Care Facilities (ICFs/IID). The ICFs/IID are residential facilities of four or more beds providing 24-hour care. Funding for ICF/IID 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.

10.2.2 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.

10.2.3 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.

10.3 Department of Assistive and Rehabilitative Services

10.3.1 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 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 80 percent of eligible blind and visually impaired children successfully complete program services.

Strategy 1-2-1. Children's Blindness Services. 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.

Objective 1-3. Autism Services. To provide services to Texas children ages 3-15 diagnosed with autism spectrum disorder.

Strategy 1-3-1. Autism Program. To provide services to Texas children ages 3-15 diagnosed with autism spectrum disorder.

10.3.2 Goal 2: Persons with Disabilities

Provide persons with disabilities quality services leading to employment and living independently.

Objective 2-1. Rehabilitation Services—Blind. To provide 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. IL Services and Council—Blind. Provide quality, statewide 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. Work with the State Independent Living Council to develop the State Plan for Independent Living.

Strategy 2-1-2. BEST Program. 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 (BET). 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 each biennium.

Strategy 2-2-1. Contract Services—Deaf. Develop and implement a statewide program to ensure continuity of services to persons who are deaf or hard of hearing. Ensure more effective coordination and cooperation among public and nonprofit organizations providing social and educational services to individuals who are deaf or hard of hearing.

Strategy 2-2-2. Education, Training, Certification—Deaf. Facilitate communication access activities through training and educational programs to enable individuals who are deaf or hard of hearing to

attain equal opportunities to participate in society to their potential and reduce their isolation regardless of location, socioeconomic status, or degree of disability. To test interpreters for the deaf and hard of hearing to determine skill level and certify accordingly, and to regulate interpreters to ensure adherence to interpreter ethics.

Strategy 2-2-3. Telephone Access Assistance. Ensure equal access to the telephone system for persons with a disability (estimated and nontransferable).

Objective 2-3. General Disabilities Services. To provide 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. Centers for Independent Living. Work with centers for independent living to establish the centers as financially and programmatically sustainable and accountable for achieving independent living outcomes with their clients.

Strategy 2-3-3. IL Services and Council—General. Provide quality, statewide consumer-directed independent living services that focus on acquiring skills and confidence to live as independently as possible in the community for eligible peple with significant disabilities. Work with the State Independent Living Council to develop the State Plan for Independent Living.

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.

10.3.3 Goal 3: Disability Determination

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 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.

10.3.4 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.

10.4 Department of Family and Protective Services

10.4.1 Goal 1: Statewide Intake Services

Ensure access to child and adult protective services, child care regulatory services, and 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 definitions.

10.4.2 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 2015, 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 Contracted Day Care. Provide purchased day care services for children in foster care, living with a relative or designated caregiver, or living at home.

Strategy 2-1-4. 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 2-1-5. 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 2-1-6. 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 2-1-7 Substance Abuse Purchased Services. Provide purchased residential chemical dependency treatment services for adolescents who are in the conservatorship of DFPS and/or parents who are referred to treatment by DFPS.

Strategy 2-1-8. 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 2-1-9. Foster Care Payments. Provide financial reimbursement for the care, maintenance, and support of children who have been removed from their homes and placed in licensed, verified childcare facilities.

Strategy 2-1-10. Adoption/ Permanency Care Assistance (PCA) Payments. Provide grant benefit payments for families that adopt foster children with special needs and for relatives that assume permanent managing conservatorship of foster children, and one-time payments for non-recurring costs.

Strategy 2-1-13. Relative Caregiver Payments. Provide monetary assistance for children in the state relative and other designated caregiver program.

10.4.3 Goal 3: Prevention Programs

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. Provide Prevention Programs. 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 ages 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/neglect and juvenile crime.

Strategy 3-1-6. At-Risk Prevention Program Support. Provide program support for at-risk prevention services.

10.4.4 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 mental health and intellectual disability facility 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 2015, deliver protective services to 75 percent of vulnerable adults at risk of maltreatment so that abuse/neglect/exploitation does not exceed 12.6 per 1,000, and provide thorough and timely investigations of reports of maltreatment in mental health and intellectual disability settings.

Strategy 4-1-1. APS Direct Delivery Staff and MH/ID Investigations. Provide caseworkers and related staff to conduct investigations and provide or arrange for services for vulnerable adults in their own homes, and to conduct investigations for persons receiving services in mental health and intellectual disability facility settings.

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. APS Purchased Services. Provide purchased services on an emergency basis for in-home clients in confirmed cases to help alleviate the abuse, neglect, or exploitation.

10.4.5 Goal 5: Child Care Regulation

Achieve a maximum level of compliance by 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 2015, 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 43.6 percent of all validated incidents.

Strategy 5-1-1. Child Care Regulation. Provide a comprehensive system of consultation, licensure, and regulation to ensure maintenance of minimum standards by day care and residential child

care facilities, registered family homes, child-placing agencies, facility administrators, and child-placing agency administrators.

10.4.6 Goal 6: Indirect Administration

Objective 6-1. Indirect Administration.

Strategy 6-1-1. Central Administration.

Strategy 6-1-2. Other Support Services.

Strategy 6-1-3. Regional Administration.

Strategy 6-1-4. IT Program Support. Information technology program support.

10.4.7 Goal 7: Information Technology Projects

Objective 7-1. Information Technology Projects.

Strategy 7-1-1. Agency-wide Automated Systems. Develop and enhance automated systems that serve multiple programs (capital projects).

10.5 Department of State Health Services

10.5.1 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 Prevention. Provides a strong, flexible public health system necessary to be prepared for and respond to any large scale public health disaster.

Strategy 1-1-2. Health Data and Analysis. Concerns the collection, analysis, and dissemination of health data to aid in monitoring, evaluating, and improving public health. Also includes the maintenance of the basic identity documents pertaining to all Texans, along with the registries that collect health information for research purposes.

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. Provides services to prevent, control, reduce, and eliminate vaccine-preventable diseases in children and adults, with emphasis on children under 36 months of age.

Strategy 1-2-2. HIV/STD Prevention. Provides human immunodeficiency virus (HIV)/sexually transmitted disease (STD) surveillance, prevention and service programs, and public education about HIV/STD disease prevention.

Strategy 1-2-3. Infectious Disease Epidemiology, Surveillance, and Control. Plays a vital role in defining, maintaining, and improving public health response to disasters, disease outbreaks, or healthcare-associated infections and in creating plans for effective disease prevention.

Strategy 1-2-4. TB Surveillance and Prevention. The TB program conducts statewide activities to prevent and control tuberculosis among individuals who reside in Texas. It supports the efforts of health departments, health care providers and communities in developing, implementing and assuring compliance with effective tuberculosis control strategies, standards, and polices.

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. Chronic Disease Prevention. Provides health promotion and wellness activities for the elimination of health disparities and the reduction of primary/secondary risk factors for certain common, disabling chronic conditions that place a large burden on Texas healthcare resources.

Strategy 1-3-2. Reduce the Use of Tobacco Products. Provides comprehensive tobacco prevention and control activities.

Strategy 1-3-3. Abstinence Education. Provides abstinence education to priority populations to decrease the birth rate among teens, decrease the proportion of adolescents engaged in sex,

decrease the incidence of sexually transmitted infections in adolescents, and increase adolescents' interest in further education.

Strategy 1-3-4. Kidney Health Care. Provides health care specialty services and the infrastructure required to determine client eligibility and to process claims.

Strategy 1-3-5. Children with Special Health Care Needs. Provides services to eligible children with special health care needs in the areas of early identification, diagnosis, rehabilitation, family support, case management, and quality assurance.

Strategy 1-3-6. Epilepsy Services. Provides treatment support and/or referral assistance to reduce disability and premature death related to epilepsy.

Strategy 1-3-7. Hemophilia Services. Provides treatment support and/or referral assistance to reduce disability and premature death related to hemophilia.

Objective 1-4. Laboratory Operations. To operate a reference laboratory in support of public health program activities.

Strategy 1-4-1. Laboratory Services. Provides laboratory testing to diagnose and investigate community health problems and health hazards.

10.5.2 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 though community based providers.

Strategy 2-1-1. Provide WIC Services. Provides nutrition education and food assistance to eligible infants, children, and women and provides breastfeeding promotion and support. Also provides nutrition, physical activity, and obesity prevention; public health surveillance; planning and policy development; funding for community-based interventions; facilitation of state/local coalitions to promote nutrition; training for medical and public health professionals; and public education.

Strategy 2-1-2. Women and Children's Health Services. Provides direct, enabling, population-based, and infrastructure-building services for women and children.

Strategy 2-1-3. Family Planning Services. Provides direct family planning services for women, men, and adolescents, and population-based activities.

Strategy 2-1-4. Community Primary Care Services. Provides services to the medically uninsured, underinsured, and indigent persons who are not eligible to receive services from other funding sources; assesses the need for health care; designates parts of the state as health professional shortage areas; recruits and retains providers to work in underserved areas; identifies areas that are medically underserved; and provides funding to communities for improved access to primary medical/dental/behavioral health care.

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. Provides community services designed to allow adults with mental illness to attain the most independent lifestyle possible.

Strategy 2-2-2. Mental Health Services for Children. Provides community services for children and adolescents ages 3-17.

Strategy 2-2-3. Community Mental Health Crisis Services. Ensures statewide access to competent rapid response services, avoidance of hospitalization, and reduction in the need for transportation.

Strategy 2-2-4. NorthSTAR Behavioral Health Waiver. Provides managed behavioral healthcare services to persons residing in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwell counties.

Strategy 2-2-5. Substance Abuse. Establishes, develops, and implements coordinated and integrated prevention, treatment, and recovery substance abuse services.

Objective 2-3. Build Community Capacity. 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. Develops a statewide emergency medical services (EMS) and trauma care system that is fully coordinated with all EMS providers and hospitals.

Strategy 2-3-2. Indigent Health Care (UTMB). Provides funds for unpaid health care services to expand access to health care.

Strategy 2-3-3. County Indigent Health Care Services. Provides reimbursement upon request to counties not fully served by a public

hospital or a hospital district once they have expended 8% of their General Revenue Tax Levy on indigent health care.

10.5.3 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 Diseases (TCID). Provides for more than one level of inpatient and outpatient care, education, and other services for patients with TB or Hansen's disease.

Strategy 3-1-2. Rio Grande State Outpatient Clinic. Coordinates, delivers, and supports needed public health services to care for patients in the Lower Rio Grande Valley.

Strategy 3-1-3. Mental Health State Hospitals. Provides specialized inpatient services in state psychiatric facilities.

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. Provides inpatient services in response to local needs through small psychiatric hospitals.

10.5.4 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. Licenses, inspects, and regulates manufacturers, producers, wholesale distributors, food managers and workers, harvest areas, meat and poultry processors, rendering facilities, and retailers of foods, drugs, and medical devices.

Strategy 4-1-2. Environmental Health. Protects the public from exposure to asbestos, lead-based paints, hazardous chemicals and other agents through various means including licensing, inspection, investigation, collection and dissemination of data, enforcement, and consultation.

Strategy 4-1-3. Radiation Control. Ensures the effective regulation of all sources of radiation.

Strategy 4-1-4. Health Care Professionals. Ensures timely, accurate issuance of licenses, registrations, certifications, permits, or documentations and investigates complaints and takes enforcement action as necessary to protect the public.

Strategy 4-1-5. Health Care Facilities. Assures quality health care delivery by regulating health facilities/entities and organizations that provide care and services to the Texas consumers.

Strategy 4-1-6. TEXAS.GOV. Establishes a common electronic infrastructure through which Texas citizens, state agencies, and local governments are able to register and renew licenses

10.5.5 Goal 5: Indirect Administration

Objective 5-1. Manage Indirect Administration.

Strategy 5-1-1. Central Administration.

Strategy 5-1-2. IT Program Support.

Strategy 5-1-3. Other Support Services.

Strategy 5-1-4. Regional Administration.

10.5.6 Goal 6: Capital Items

Objective 6-1. Manage Capital Projects.

Strategy 6-1-1. Laboratory (Austin) Bond Debt. Pays debt service on special revenue bonds issued to build a laboratory and parking structure.

Strategy 6-1-2. Repair and Renovation: MH Facilities. Funds the necessary repair, renovation, and construction projects required to maintain the state's psychiatric hospitals at acceptable levels of effectiveness and safety.

10.5.7 Goal 7: Office of Violent Sex Offender Management

Objective 7-1. Office of Violent Sex Offender Management.

Strategy 7-1-1. Office of Violent Sex Offender Management. Performs the duties related to the sexually violent predator civil commitment program.

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