



Health and Human Services System Strategic Plan 2013-17

Volume I



Health and Human Services Commission

Department of Aging and Disability Services

Department of Assistive and Rehabilitative Services

Department of Family and Protective Services

Department of State Health Services



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Department of State Health Services

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**Health and Human Services System Strategic Plan
2013-17**

Health and Human Services Commission



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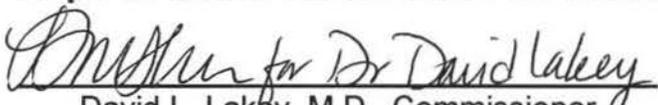
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Texas Health and Human Services System Strategic Plan 2013-17

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Figure A
Map of the Health and Human Services System Regions



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, 78th Legislature, Regular Session, 2003, the Governor and Legislature directed the Texas health and human services agencies to consolidate twelve agencies into five in an effort to streamline organizational structures, eliminate duplicative administrative systems, and more effectively and efficiently deliver health and human services to Texans.

H.B. 2292 assigned 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 2010, 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 strong economic position relative to other states and the nation is 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 businesses, 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 few 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 make sure 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 to chart 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.

1.4 Philosophy of Texas State Government

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

- First and foremost, Texas matters most. This is the overarching, guiding principle by which we will make decisions. Our state, and its future, is more important than party, politics, or individual recognition.
- Government should be limited in size and mission, but it must be highly effective in performing the tasks it undertakes.
- Decisions affecting individual Texans, in most instances, are best made by those individuals, their families, and the local government closest to their communities.
- Competition is the greatest incentive for achievement and excellence. It inspires ingenuity and requires individuals to set their sights high. Just as competition inspires excellence, a sense of personal responsibility drives individual citizens to do more for their future and the future of those they love.
- Public administration must be open and honest, pursuing the high road rather than the expedient course. We must be accountable to taxpayers for our actions.
- State government has a responsibility to safeguard taxpayer dollars by eliminating waste and abuse and providing efficient and honest government.

- Finally, state government should be humble, recognizing that all its power and authority is granted to it by the people of Texas, and those who make decisions wielding the power of the state should exercise their authority cautiously and fairly.

1.5 Statewide Goals and Benchmarks for Health and Human Services

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

1.5.1 Health and Human Services Priority Goal

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

- *Making public assistance available to those most in need through an efficient and effective system while reducing fraud;*
- *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 Supplemental Nutrition Assistance Program (SNAP) benefits; and
- Number of Texans using call centers and the Internet to apply for Medicaid, SNAP benefits, and other state services.

Statewide Benchmarks Relevant to DADS

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

Statewide Benchmarks Relevant to DARS

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

Statewide Benchmarks Relevant to DFPS

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

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;

- Percentage of births that are out-of-wedlock;
- Number of women served through Title V prenatal care services;
- Percentage of screened positive newborns who receive timely follow-up (Title V newborn screening);
- Rate of substance abuse and alcoholism among Texans;
- Number of women served through the Texas Breast and Cervical Cancer Program;
- Readiness score by the CDC on the state Antiviral Allocation, Distribution, and Storage Plan;
- Number of Federally Qualified Health Centers (FQHCs) since the inception of the Texas FQHC Incubator Program;
- Number of people who receive mental health crisis services at community mental health centers;
- Number of state funded cancer research grant projects;
- Amount of leveraged dollars invested in state funded research grant projects; and
- Number of Texans enrolled in Healthy Texas.

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 via 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 2013-17, there will likely 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 work. Chapters 5 through 9 contain each agency's challenges and opportunities, including planned actions to improve customer service while maintaining accountability to taxpayers. Chapter 10 presents each agency's Goals, Objectives, and Strategies associated with the agency's budget and listed in the General Appropriations Act. The Appendices provide in-depth information about the workforce and other topics.

Note: At the time of publication, the U.S. Supreme Court had not ruled on the constitutionality of the Patient Protection and Affordable Care Act of 2010, which would affect programs across the HHS System.

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, primary care, disease prevention, and early intervention in a quality-oriented, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Improve access to effective behavioral health, prevention, and treatment services.
- Promote the delivery of locally-driven health care that integrates both physical and behavioral health services.

- Work with partners to develop public health strategies to improve outcomes and to contain health care costs.
- Ensure programs and initiatives recognize and address health disparities and disproportionality to improve outcomes across all programs.
- Continue to improve disaster preparedness and response, including prevention of future threats.

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

- Ensure policies and services that encourage responsibility and improve access to employment.
- Partner with persons with disabilities, including persons with mental illness, in overcoming barriers to full participation in the community and the labor market.
- Assist older Texans and those with disabilities to gain, maintain, and enhance their ability to function independently.
- Ensure children who have intellectual disabilities and/or developmental delays have the same opportunities as other Texans to pursue independent and productive lives.
- Support children and youth in HHS 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 state-regulated, operated, and contracted facilities, as well as those served in their homes.
- Improve detection of potential risk to vulnerable children and adults in the community and in state facilities and ensure that appropriate services are offered and provided when abuse, neglect, or exploitation occurs.
- Create a regulatory environment that fosters the health, safety, and opportunities of Texans while ensuring a pro-business environment that supports accountability and innovation.
- Work with local law enforcement to support investigations and prosecutions of people suspected of criminal abuse, neglect, or exploitation.

2.4.4 Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Work closely with faith- and community-based organizations to assist people in applying for nutrition, medical, and monetary assistance, and other service needs.
- Continue to develop and improve volunteer programs to support service delivery.
- Engage communities in developing service delivery systems, programs, and policies.

2.4.5 Ensure 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, cost-effective, and customer-friendly.
- Recruit high quality employees.
- 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.
- Promote safety and wellness, by providing an accessible, secure, safe work environment and by training employees to respond appropriately to difficult or dangerous situations, whether in the office or in the field.
- Use technology to maximize work efficiency and eliminate costly maintenance and repair on unneeded and underutilized office space.
- Encourage innovation and teamwork.

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. Key demographic trends to watch include the aging of the population, increased longevity, and more race/ethnic diversity.

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

Rapidly changing economic conditions have had an impact on the demand for health and human services. Since the start of the recession in 2007, key health and human services programs such as Medicaid, Children's Health Insurance Program (CHIP), and the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) have experienced caseload increases. Similarly, other important programs, such as those administered by the Texas Department of Family and Protective Services, have also experienced caseload 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 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 Growth¹

Since becoming a state in 1845, Texas has consistently experienced higher population growth compared to the rest of the nation. This rapid growth has accelerated during the last 30 years and continues to be very strong today. From 2000 to 2010, the state’s population grew by almost 4.3 million, reaching a total of 25.1 million. The population growth rate for the state between 2000 and 2010 was 21 percent. This growth rate is slightly more than twice as high as the growth rate for the United States (U.S.) as a whole over the same period.² During that period, the Texas share of the national population grew from 7 to 8 percent.³ With a total population already surpassing 25 million, Texas ranks second in total population, after California, which in 2010 had a population of nearly 38 million.

According to analyses done by the U.S. Census Bureau, natural increase (population growth resulting from the birthrate being greater than the number of deaths) accounted for 54 percent of the growth, while positive net migration (population growth resulting from the number of incoming migrants being greater than number of outgoing migrants) accounted for 46 percent. In the last few years,

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

² U.S. Census Bureau.

³ Ibid.

international migration has had a significant impact on population growth. For example, of the almost 1.8 million persons who moved into the state between 2000 and 2009, approximately 52 percent or 933,000 were international migrants. However, more recent analyses suggest the pace of international immigration may have slowed. The Census Bureau has estimated that between 2010 and 2011, international migrants comprised 39 percent of all migrants moving into the state.

By 2013, the state's total population is expected to reach 26.9 million, for an increase of 1.8 million over the 25.1 million that were counted during the Census of 2010. Between 2013 and 2017, the state's total population is projected to grow by another 2.2 million or 8 percent, for a total of 29.1 million. Between 2013 and 2040, the state's population is projected to grow by an additional 17.9 million, or 67 percent, for a total of 44.9 million.

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 2013-17, and it is also useful to discuss potential long-term trends. The population of people age 65 and older is projected to increase from 2.8 million in 2013 to 7.5 million in 2040. The percentage of the total population that is 65 years of age or older is projected to increase from 10 percent in 2013 to 17 percent by 2040. Similarly, the percentage of the population 85 years of age or older is also projected to increase, doubling from 1 percent in 2013 to 2 percent in 2040.

The median age for the Texas population as a whole, which stood at 33.6 years during the Census of 2010, is projected to increase to 37.8 years in the year 2040.⁴ The median age is projected to increase for all major race/ethnic groups.

Although the population of people age 65 or older is projected to grow across all race/ethnic groups, the growth will be more dramatic in the non-Anglo groups. Between 2013 and 2040, the following growth rates are projected in the population of persons age 65 or older:

- Anglos—54 percent,
- African Americans—189 percent,
- Hispanics—352 percent, and
- All other groups (combined)—892 percent.

Figure 3.1 depicts the projected growth trend for the population age 65 and older during the 2013-40 period according to race/ethnicity. In the 65 and older population, the Anglo population is projected to grow from 1.8 million to 2.8 million; the African-American population is projected to grow from 242,000 to 700,000; and the Hispanic population is projected to grow from 589,000 to 2.7 million. For all

⁴ Ibid.

other groups combined, the population is projected to grow from 130,000 to 1.3 million over the same period.

Figure 3.1
Texas Population Age 65 and Older by Race/Ethnicity,
Years 2013 and 2040

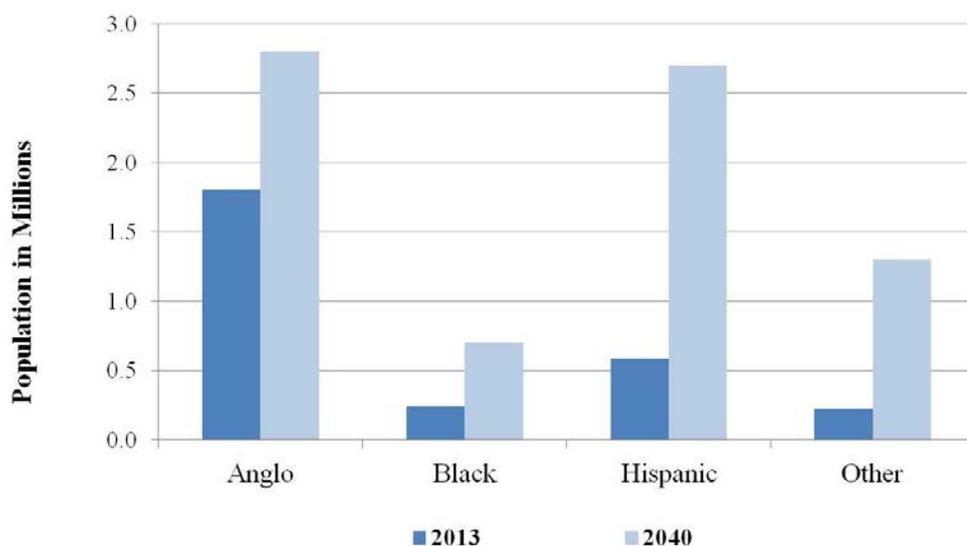


Figure 3.1: Texas State Data Center; Health and Human Services System - Strategic Decision Support.

Prevalence of Disability

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

The American Community Survey (ACS) for Texas, which is conducted by the U.S. Census Bureau, indicates that in 2010 there were approximately 3 million, or 12 percent of all Texans, who lived with a disability. Among adults aged 18-64, the ACS reports that 10.5 percent had a disability in 2010. Among adults aged 65 and older, the ACS reports that 42.3 percent live with a disability. Figure 3.2 illustrates the percent of the population with a disability according to age group.

Figure 3.2
Percent of Texans with Disability in 2010 by Age Group

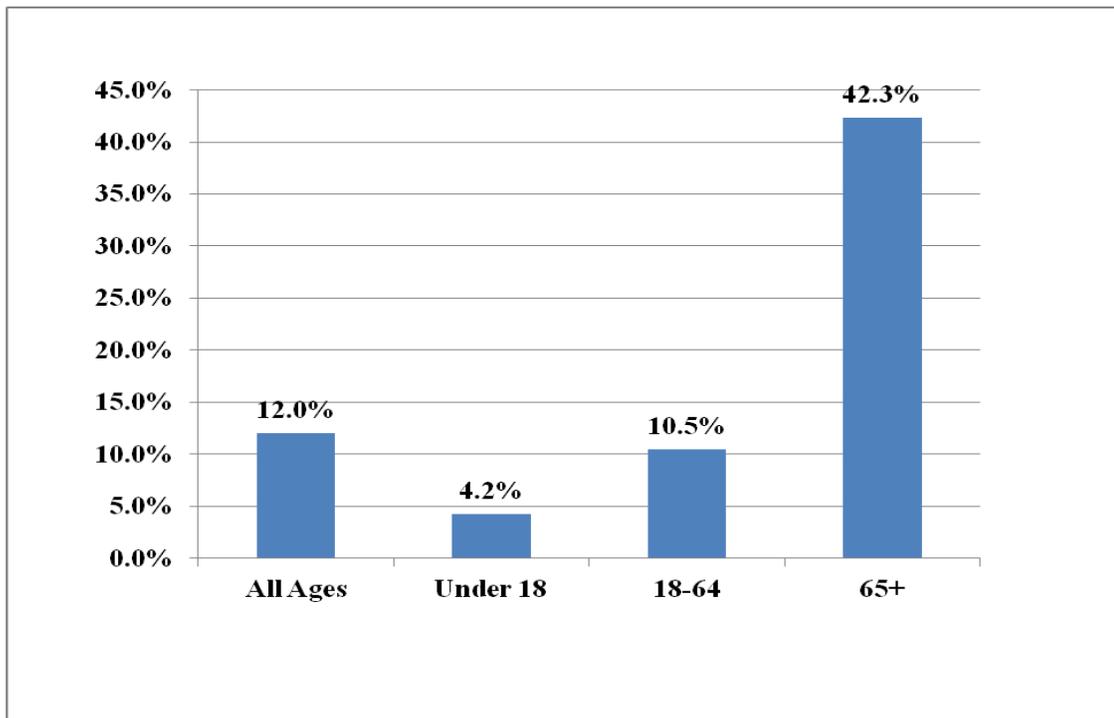


Figure 3.2: U.S. Census Bureau, 2010 American Community Survey for Texas; Health and Human Services System - Strategic Decision Support.

Race/Ethnic Composition of the Population

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

In 2013, Anglos are projected to comprise 43 percent of the population, while Hispanics are projected to comprise 41 percent. African Americans are projected to comprise 11 percent, and other groups are projected to account for the remaining 5 percent.

The SDC projects the following growth trends between 2013 and 2017.

- The Anglo population is projected to grow from 11.5 to 11.6 million, for a growth rate of less than 1 percent.
- The African-American population is projected to grow from 3.1 to 3.3 million, for a growth rate of 7 percent.
- The Hispanic population is projected to grow from 11.0 to 12.6 million, for a growth rate of 15 percent.
- The population of all other population groups (combined) is projected to grow from 1.3 to 1.6 million, for a growth rate of 23 percent.

The high growth rate projected for the non-Anglo populations, which historically have experienced a higher rate of poverty, could further accelerate the demand for services. Key areas such as public health could be affected as certain diseases and health conditions tend to be more prevalent in some racial-ethnic groups compared to others—for example, Type II Diabetes among Hispanics.⁵ 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 (DSHS) Strategic Plan.

Rural Population Concerns

The trend toward greater urbanization in Texas is expected to continue during the foreseeable future. Based on the U.S. Office of Management and Budget classification, there are 77 Texas counties that are classified as metropolitan, while 177 are classified as non-metropolitan.⁶ The SDC projects that in 2013, approximately 3.2 million or 12 percent of the total population of 26.9 million will reside in non-metropolitan counties, while 23.7 million, or 88 percent of the total population, are projected to reside in metropolitan counties. According to the SDC, between 2013 and 2017 non-metropolitan counties will add approximately 75,000 new residents, while metropolitan counties are projected to add another 2.1 million.

Counties or areas that are more rural and isolated 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,

⁵ Texas Behavioral Risk Factor Survey (<http://www.dshs.state.tx.us/chs/brfss/>).

⁶ 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 to be typically classified as non-metropolitan.

- Increased need for geriatric services,
- Prolonged response times for emergency,
- Limited job opportunities and other incentives for youth to stay in the community,
- Limited transportation options,
- Limited economic development, and
- Limited fiscal resources.

3.1.2 Economic Forecast

The economic climate in Texas has experienced improvement since 2011. For example, according to the Texas Workforce Commission, on a seasonally adjusted basis, the Texas unemployment rate decreased by 1.1 percent from April 2011 to April 2012. The rate of unemployment was 6.9 percent in April 2012, compared to 8.0 percent in April 2011. The number of employed adults increased by more than 300,000 during the same period.

The Texas Comptroller of Public Accounts has reported that gross sales and tax collections increased in 2011 over 2010 in the “State Sales and Use Tax Analysis.” Increases in gross sales and related tax collections are a sign of an improved economic climate.

In spite of these improvements, the impact of the recession that began in 2007 is still felt in a variety of ways. For example, Texas continues to have a higher than average rate of poverty and higher than average percentage of persons without health insurance coverage. In the labor market front, there is still room for improvement, considering that the unemployment rate in December 2011 was almost twice as high compared to December 2007.

In addition, in February of 2012 participation levels in means-tested programs such as SNAP, Medicaid, and CHIP were near the historically high participation levels that were reached during the latter part of 2011.

Poverty

People living in poverty often rely on health and human services, so it is useful to review trends in this population, to look for potential impacts on the HHS System.

The U.S. Department of Health and Human Services defined the poverty level for 2012 as an annual gross income as follows:

- \$23,050 or less for a family of four,
- \$19,090 or less for a family of three,
- \$15,130 or less for a family of two, and

- \$11,170 or less for individuals.

According to the U.S. Census Bureau's March 2011 Current Population Survey (CPS) for Texas, an estimated 4.6 million Texans, or 18.4 percent of the population, lived in households/families with annual incomes falling below the federal poverty level in 2008.⁷ Research done by Texas Health and Human Services Commission (HHSC) Strategic Decision Support staff indicates that if the poverty rate were to hold steady at 18.4 percent during the foreseeable future, the number of Texans in households/families with incomes below the poverty level would increase to approximately 5 million by 2013 and to 5.4 million by 2017.

Poverty and Race/Ethnicity

The percent of the population below the poverty level varies by race and ethnicity. According to the March 2011 CPS, 8 percent of Anglos, 23 percent of African Americans, 29 percent of Hispanics, and 14 percent of persons in all other groups lived in households/families with incomes below the poverty level in 2010.

The percent of the child population younger than age 18 living below the poverty level also varies by race/ethnicity, with the percentages being higher for non-Anglo children. In 2010, 9 percent of Anglo children lived in families with annual incomes below the federal poverty level, compared to 31 percent of African-American children, 38 percent of Hispanic children, and 12 percent of children in other groups.

3.1.3 Health Trends

Health Insurance Coverage

The U.S. Census Bureau's March 2011 CPS gathered health insurance coverage information for 2010, reporting new information.

- There were 6.2 million Texas residents without health insurance, counting both citizens and non-citizens; this number represented 25 percent of the Texas population.
- Among the 75 percent of Texas residents who had health insurance, the most prevalent form of coverage was employer-based private insurance.
- Approximately 51 percent of the Texans younger than age 65 had employer-based health insurance.
- More than 91 percent of the population age 65 and older was covered by Medicare.
- An estimated 1.2 million Texas children under age 18, or 16 percent, were uninsured.

⁷ U.S. Census Bureau, March 2011 Current Population Survey (CPS) for Texas.

In recent years, the percentage of the population younger than age 65 who had private health insurance coverage has declined both nationally and in Texas. In Texas, the percent of the population covered by any type of private insurance declined from 67 percent in 2000 to 56 percent in 2010. Compared to other states, Texas had the fourth-lowest percentage (after New Mexico, Mississippi, and Louisiana) for private health insurance coverage among persons under the age of 65 in 2010.

The percentage of children younger than age 18 who had private health insurance also varied according to race/ethnicity in 2010. At that time, approximately 71.3 percent of Anglo children were covered by private health insurance while only 42.6 percent of African-American and 32 percent of Hispanic children were covered by private health insurance.⁸

Medicaid and CHIP, both operated by the state, experienced increased enrollment levels from 2009 to 2011, the most recent time for which data are available. In September 2011, approximately 3.4 million low-income children younger than age 19 were enrolled in Medicaid and CHIP, which is nearly 47 percent of all the children in the state. This level is an increase of approximately 445,000 children since September 2009.

Changes to federal health policy may have an impact on the size of the population that is served by the Medicaid program. Beginning in 2014, Texas could see an additional 1.8 million persons enrolled in the Medicaid program. From 2014 to 2023, persons coming into the program under federal requirements could cost Texas approximately \$18.1 billion in general revenue funds; with federal matching funds added, the total cost could reach \$161.8 billion.⁹

Impact of Natural Disasters and Pandemic Disease

In recent years, DSHS has engaged in a variety of public health emergency response activities. In addition to severe storms, recent response activities include historic wildfires and the first influenza pandemic in over 40 years.

Bastrop Wildfires

On September 4, 2011, a wildfire started burning near the city of Bastrop, Texas, and continued burning for over five weeks. The impact of the Bastrop Wildfire included:

- Over 34,000 acres burned,

⁸ State Health Access Data Assistance Center, "Current Population Survey 2010."
(<http://www.shadac.org>)

⁹ HHSC. April 22, 2010. "Federal Health Care Reform – Impact to Texas Health and Human Services," Presentation to the House Select Committee on Federal Legislation.
(<http://www.hhsc.state.tx.us/news/presentations/2010/HouseSelectFedHlthReform.pdf>).

- An estimated 1,649 homes destroyed, and
- Two fatalities.

DSHS activated the State Medical Operations Center. A Mobile Medical Team and response trailer were deployed and provided 24-hour medical assistance and medications for six days at the firefighter base camp. Shelters were supported by providing prescription medications and other medical supplies. Four contingency pharmacy contracts were activated to improve prescription medication access for those who lost their medications. A Community Assessment for Public Health Emergency and Response team was deployed from the DSHS Central Office to assess the public health impact of the wildfires across the region. Additionally, DSHS Health Service Region 7 staff was deployed to work with state emergency management officials co-located at the local emergency operations center in the Bastrop city conference center.

Other activities by DSHS included:

- Providing public information, such as press releases (in English and Spanish) on topics that included evacuation safety, smoke precautions, and recovery hazards;
- Activating an epidemiology surveillance system; and
- Providing crisis-counseling services through the federal Crisis Counseling Program, Texas P.R.I.D.E. (People Recovering In Spite of Devastating Events).

Novel H1N1 Pandemic

In April 2009, DSHS became actively involved in the H1N1 pandemic when two Texas H1N1 patients were confirmed in Guadalupe County nine days after the first two cases of H1N1 in the U.S. were recognized in California. The impact of the H1N1 pandemic included:

- 240 deaths,
- 2,316 hospitalizations, and
- 585 intensive care unit admissions.

DSHS responded through the use of public-private partnerships to distribute the state's antiviral stockpile. Local health departments provided medications and private pharmacies and federally qualified health centers managed state stock to distribute to individuals with valid prescriptions. As medical countermeasures were distributed across the state, public health surveillance activities and laboratory testing systems surged to meet the demands of the monitoring and testing needed to understand and track the spread of the virus. Additionally, the public was kept informed through a multi-faceted communication strategy that included informing and educating both health care providers and the public regarding the H1N1 influenza pandemic.

Health Risk Factors

In 2009, 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 2009.

Table 3.1
Leading Causes of Texas Deaths, 2009¹⁰

Ranking	Disease	Percentage
1	Heart Diseases	23.3%
2	Cancer	21.8%
3	Accidents	5.7%
4	Stroke-Related	5.6%
5	Lung Diseases	5.3%
6	Alzheimer's Disease	3.1%
7	Diabetes-Related	3.0%
8	Kidney Disease	2.3%
9	Influenza and Pneumonia	2.1%
10	Blood Infections	1.9%
All Other Causes		25.9%
Total Deaths in 2009		100.0%

Table 3.1: Department of State Health Services.

¹⁰ DSHS, "Vital Statistics Annual Report: Leading Causes of Mortality."
<http://www.dshs.state.tx.us/chs/vstat/vs09/t16.shtm>.

Five of the top six leading causes of death in Texas in 2009 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. Cancer represents more than 100 distinct diseases that are all characterized by the uncontrolled growth and spread of abnormal cells in the body. Risk factors associated with cancer include tobacco use, poor nutrition, physical inactivity, and obesity. Diabetes can lead to disabling health conditions, such as heart disease, stroke, kidney failure, leg and foot amputations, and blindness. The 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,
- Irresponsible 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 1980's and 1990's serve as the basis for prevalence estimates for the adult population.¹¹ 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 2010 estimated number of adults with serious and persistent mental illness was 488,520. 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

¹¹ 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>)

comprise approximately 5 to 9 percent of children ages 9 to 17.¹² The estimated number of children with SED in Texas in 2010 was 154,724.

Behavioral Risk Factors

The leading causes of death can be linked to one or more significant behavioral risk factors. Three risk behaviors are major contributors to cardiovascular disease and cancer: 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 and report the following information.¹³

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 2007, the economic impact of alcohol abuse was estimated to be \$21.2 billion, which includes health care expenditures, lost productivity, motor vehicle accidents, crime, and other costs.¹⁴
- Of the 3,023 motor vehicle fatalities in 2010, 1,075 (35.6 percent) were alcohol-related.¹⁵
- Alcohol continues to be the most widely used controlled substance among secondary school students. In 2010, 62 percent of high school students reported they had used alcohol, while 29 percent reported past-month alcohol use.¹⁶

Alcohol was the controlled substance that was easiest for secondary students to obtain, with parties and friends being the major sources.

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

- The economic impact of illegal drug use in 2007 was roughly estimated to be \$12.2 billion;
- Approximately 45 percent of secondary school students reported that they were not drug-free from all substances, including alcohol, during the 2010 school year; and
- In 2008, 25 percent of all adults served in the public mental health system were diagnosed with a co-occurring substance abuse disorder.¹⁷

¹² Ibid.

¹³ DSHS, BRFSS. (<http://www.dshs.state.tx.us/chs/brfss/default.shtm>).

¹⁴ Mental Health and Substance Abuse Decision Support Update to the Economic Cost of Alcohol and Drug Abuse, 2000.

¹⁵ National Highway Traffic Safety Administration's Fatality Analysis Reporting System. (<http://www-fars.nhtsa.dot.gov/Main/index.aspx>)

¹⁶ DSHS, "2010 Texas School Survey of Substance Abuse among Students in Grades 7-12."

¹⁷ Mental Retardation and Behavioral Health Outpatient Warehouse, 2010.

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 – more than the total number killed by acquired immunodeficiency syndrome (AIDS), alcohol, motor vehicle accidents, homicides, illegal drugs, and suicide combined. In Texas, 24,200 adults die annually from smoking-related causes. This equates to one person every 22 minutes. Additionally, for every person who dies from a tobacco-related cause, an additional 20 suffer from tobacco-related diseases.

Economically, tobacco use impacts Texas residents through health care costs (\$1.6 billion in Medicaid, \$5.83 billion in overall health care costs), lost productivity (\$6.44 billion), fire loss (\$13.26 million in 2009), and highway cleanup (\$20.2 million). These expenses are borne by all business and households in the state through taxes, and health care and homeowner insurance premiums.

As it relates specifically to cancer, smoking is responsible for 87 percent of lung cancer deaths. In addition to lung cancer, 30 percent of all cancer deaths are due to smoking. The Texas Cancer Registry reports that more than 15,000 Texans died annually in 2004-2008 from tobacco-related cancers. More than two-thirds of these deaths are due to cancers of the lung and bronchus (5,600 males/4,062 females). In addition, 12,709 new cases of lung cancer are diagnosed annually in the state, and it is the most commonly diagnosed cancer in the state after prostate cancer for men and breast cancer for women.

Tobacco use and its related health consequences take a high toll on lower-income and less educated populations who disproportionately use tobacco products and have less access to health care due to a lack of insurance. According to the findings from the 2010 Texas BRFSS, individuals with a high school education or less have a 41.3 percent prevalence for smoking and an 86.6 percent prevalence for not having health insurance. This study found that those who make less than \$25,000 per year have a 22 percent prevalence rate for smoking and 49 percent prevalence for lacking health insurance. This compares to a statewide average of a 15.8 percent prevalence for smoking and 23.1 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 overweight and obesity, the second leading cause of preventable mortality and morbidity in the U.S. These factors account for more than 100,000 deaths annually, and 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 2010, 66.6 percent of Texas adults were overweight or obese, compared to 62.8 percent in 2002.¹⁸
- In 2010, 31.9 percent of adult Texans were obese compared to 27.5 percent nationwide.
- In 2011, 15.6 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 percent vs. 11.19 percent).
- Hispanic students were more likely than Anglos to be obese (19.2 percent vs. 10.2 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, 26.7 percent of adults reported no leisure-time physical activity in the past month, compared to 23.9 percent of adults nationwide in 2010.
- Hispanics and African Americans in Texas had higher rates of no leisure-time physical activity, 32.3 percent and 32.6 percent respectively, compared to 23 percent of Anglos.
- In 2009, over one-third (35.4 percent) of adult Texans had insufficient physical activity according to the 2008 Physical Guidelines.
- According to the 2011 Texas YRBS, 37.2 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 52.6 percent, followed by Hispanics at 40.9 percent, and Anglos at 27.2 percent.
- One out of three Texas high school students (32.2 percent) played video games or computer games, or used a computer that was not school work for three or more hours per day on an average day in 2011.

¹⁸ DSHS, Center for Health Statistics, 2010 Texas Behavioral Risk Factors Surveillance System. (http://www.dshs.state.tx.us/chs/brfss/query/brfss_form.shtm)

3.2 Recent State and Federal Policy Direction

This discussion highlights the most significant recent policy direction for the HHS System as a whole. More agency-specific legislation passed by the 82nd Legislature is referenced in each agency's discussion of challenges, opportunities, trends, and initiatives.

3.2.1 Direction to Contain Medicaid Cost Growth

As Medicaid spending continues to grow, state policy makers have directed HHSC to pursue multiple efforts to contain Medicaid spending. For example, HHSC's Rider 61 in the 2012-13 General Appropriations Act (H.B. 1, 82nd Legislature, Regular Session, 2011) reduces HHSC's appropriation by \$450 million in general revenue based on development of new Medicaid cost containment initiatives, such as increasing neonatal intensive care management, developing more appropriate emergency department hospital rates for nonemergency related visits, and limiting the amount, scope, and duration of certain services. Additional state policy guidance provided through instructions to reduce general revenue spending across all agencies for the 2012-13 and 2014-15 biennia will continue the need to develop new initiatives to contain Medicaid spending.

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. With the fiscal outlook for the 2014-15 biennium indicating budget challenges facing the state, Medicaid cost containment efforts are expected to continue to be emphasized in the next biennium.

3.2.2 Expansion of Managed Care

Managed care is a method of health care service provision that has proved cost-effective, and the 82nd Legislature directed HHSC to expand managed care to cover more Medicaid/CHIP clients. As authorized by H.B. 1, 82nd Legislature, Regular Session, 2011, and Senate Bill (S.B.) 7, 82nd Legislature, First Called Session, 2011, HHSC expanded the Medicaid managed care STAR+PLUS program to El Paso, Lubbock, South Texas, and the adjacent counties surrounding the current STAR+PLUS areas. HHSC expanded the STAR program to South Texas and replaced the Primary Care Case Management program with the STAR program. Other directives included incorporating the prescription drug benefit into managed care, including inpatient hospital services in the STAR+PLUS capitation rate, and placing dental services into managed care. The total estimated savings for these

initiatives is \$602.6 million all funds over the biennium. For more information about these programs, see *Section 5.4.2, HHSC Goal 2: Medicaid*.

3.2.3 Health Care Quality

Article 3 of S.B. 7, 82nd Legislature, First Called Session, 2011, establishes the Texas Institute of Health Care Quality and Efficiency to improve health care quality, accountability, education, and cost-containment by encouraging provider collaboration, effective delivery models, and coordination of services.

The purpose of the Institute is to make recommendations to the Legislature on how to improve health care quality and data reporting and to support innovative health care collaborative payment and delivery systems. The institute is required to submit its recommendations in a report by December 1, 2012, to the Governor, the Lieutenant Governor, the Speaker of the House of Representatives, and the chairs of the appropriate standing committees. Additional information is included in *Section 5.4.1, HHSC Goal 1: HHS Enterprise Oversight and Policy*.

3.2.4 Federal Program Reauthorizations

Supplemental Nutrition Assistance Program

SNAP, formerly known as the Food Stamp Program, requires federal reauthorization every five years, with the current authorization set to expire on September 30, 2012. The Agriculture Reform, Food and Jobs Act of 2012 (S 3240, commonly known as the Farm Bill) is the vehicle for reauthorization in 2012.

The measure imposes a minimum monthly Low Income Home Energy Assistance Program payment, disqualifies a household for SNAP if a member of the household receives substantial lottery or gambling winnings, and bans retailers from participating in SNAP if sales attributable to liquor and tobacco exceed 45 percent of total sales. S 3240 also increases funds to combat retailer and recipient benefit trafficking, funds pilot programs for online purchasing, and funds demonstration projects designed to increase purchases of fruits and vegetables among SNAP recipients. The Farm Bill also reduces funding for an employment and training program administered by the Texas Workforce Commission and funded through the federal Food and Nutrition Service. Other potential amendments to the Farm Bill could reduce or eliminate high performance bonuses to states and eliminate categorical eligibility.

Overall, the Farm Bill makes up only about two percent of federal funding, but the largest portion of funds is spent on nutrition programs, which make up nearly 80 percent of Farm Bill spending. At this time, Congress is still debating and amending

the Farm Bill and the differences are expected to be resolved in a conference committee in September 2012.

Temporary Assistance for Needy Families

The Temporary Assistance for Needy Families (TANF) program was set to expire on September 30, 2011, but funding was continued through a short-term reauthorization through December 31, 2011. Ultimately, TANF was continued through H.R. 3630, the Middle Class Tax Relief and Job Creation Act of 2012, until December 31, 2012. The agreement includes the two new policy provisions. The first provision mandates data exchange standardization for improved data matching and to reduce fraud and abuse. The Secretary of the U.S. Department of Health and Human Services is required to issue proposed regulations within 12 months of enactment and final regulations within 24 months of enactment. The second provision requires states to adopt policies and practices to prevent TANF electronic benefit transfer transactions in liquor stores, casinos, or adult-entertainment establishments. A state would be subject to a penalty, equal to 5 percent of its TANF block grant, if it does not comply with the law within two years.

The reauthorization measure does not extend TANF supplemental grants, which expired on June 30, 2011. In addition, the law does not address the TANF Contingency Fund, because funding was previously authorized and appropriated through federal fiscal year (FFY) 2012. The President's FFY 2013 budget includes authority to reauthorize the TANF Supplemental grants, and there is support in Congress for such a move, however the budget proposes to fund the approximately \$300 million grant program by taking money from the TANF Contingency Fund. TANF supplemental grants were awarded to 17 states with high population growth, where the regular TANF block grant is not sufficient; Texas received \$52.7 million annually from the supplemental grants. There have been no new bills filed on TANF since January 2012.

Chapter 4

Health and Human Services System Cross-Agency Planning and Other Efforts

This chapter concludes 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 (CSP).

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;
- A Focus on Children;
- 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 (HHSC). Each chapter discusses the agency's external assessment, current activities, and internal assessment.

4.1 Strategic Plans and Initiatives

4.1.1 Coordinated Strategic Plan for Health and Human Services

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

Since the enactment of H.B. 2292 and the consolidation of the 12 legacy agencies into the 5 current agencies in a single HHS System, both the CSP and the HHS System agencies' Strategic Plans have been included in a single document. Chapters 2 through 4 of this document constitute the CSP required by Section 531.022 of the Texas Government Code. Since all of the System agencies have contributed to this Plan, HHSC is using its authority to consolidate reports (granted at Texas Government Code, Section 531.014) to satisfy the CSP requirement.

This Plan meets the requirements for public comment for the CSP and will be provided to all the required recipients for the CSP in July, prior to the CSP due date of October 1, 2012.

4.1.2 Technology Resources Planning

The State Strategic Plan for Information Resources Management, developed at the Department of Information Resources, provides strategic direction for technology management in Texas and highlights the building blocks needed for success. The plan focuses on ten top priorities, outlining the reasons for their importance, their relevance to Texas agencies, and a roadmap toward their implementation. The "Technology Initiative Assessment and Alignment" section, included as Appendix I of this HHS System Strategic Plan, describes how technology initiatives will be deployed within the HHS agencies to support these priorities.

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 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 agencies is included as Appendix E.

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 Texas. TWIC is required to develop a strategic plan, "Advancing Texas: Strategic Plan for the Texas Workforce Development System FY 2010 to FY 2015," that establishes the framework for budgeting and operating a workforce development system administered by agencies represented on the council. As one of those agencies, the Department of Assistive and Rehabilitative Services (DARS) provides certain performance measures for inclusion in the TWIC plan: consumers served, employment retention, and number of consumers who entered employment. "Advancing Texas" 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 2012 Update is the first review and update for "Advancing Texas" and is included in 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 law.¹ Figure 4.1 illustrates these designated regions.

The populations of both the Texas-Mexico and the Texas-Louisiana border regions are growing. From 2013 to 2017, the population in the 43 counties comprising the Texas-Mexico border region is expected to grow at a rate slightly lower than the state's population as a whole (6 percent versus 8 percent). The rate of population growth in the 18 counties in the Texas-Louisiana border region is projected to increase at a considerably lower rate (4 percent) compared to the Texas-Mexico border counties. In these two border areas, 30 counties are geographically isolated

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.

and economically distressed, which represents 70 percent of the total number of counties in the combined regions.

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

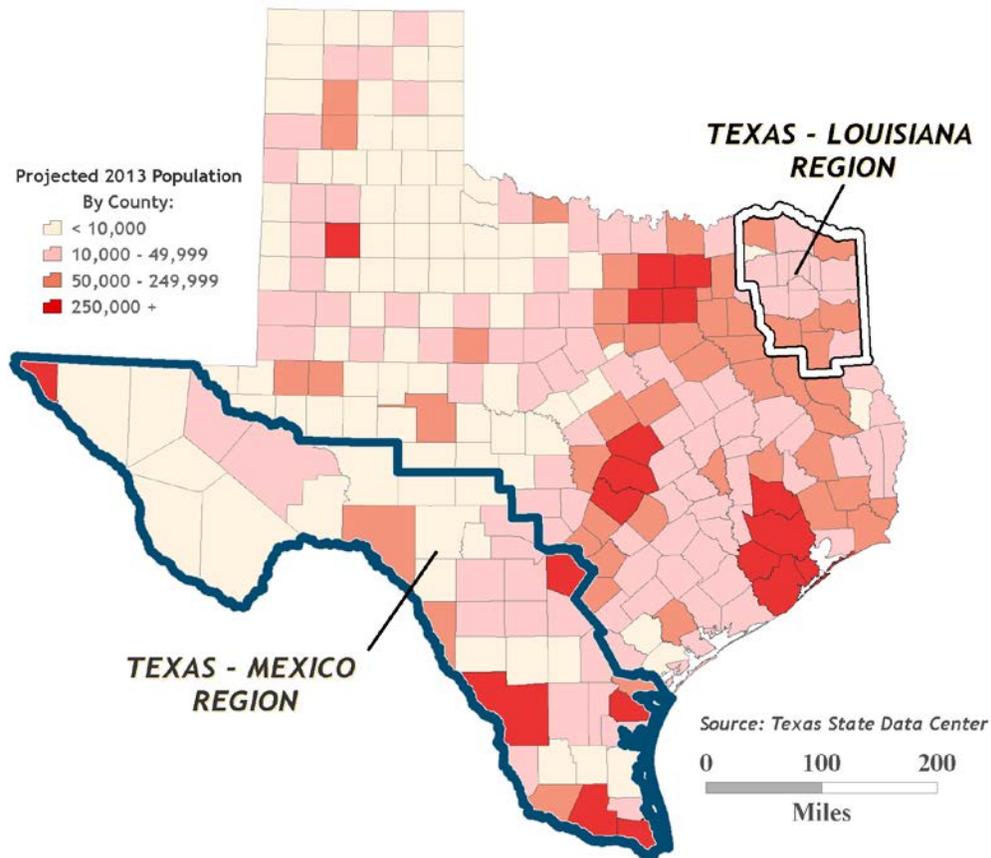


Figure 4.1: Health and Human Services Commission - Strategic Decision Support, 2012.

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 2013, the population of this region will represent approximately 19 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 2010 is 24.4 percent, which is considerably higher than the estimated rate of 18.4 percent for the state as a whole. High levels of poverty in a population or region generally result in a higher demand for health and human services.

Approximately 400,000 residents of the Texas-Mexico border live in colonias, generally described as rural, isolated, unincorporated communities with insufficient provision of public utilities such as running water, storm drainage, sewers, paved roads, electricity, and telephone service. Due to all these factors, access to health services is also a challenge. Today, more than 2,000 colonias exist in the area located primarily along the state's 1,248 mile border with Mexico.

The HHSC Office of Border Affairs was created to ensure coordination of services and supports for those living in the Texas border regions. The HHS System agencies have developed an interagency partnership with the HHSC Office of Border Affairs, the Texas Workforce Commission (TWC), local workforce development boards, the Texas Education Agency (TEA), local school districts, and educational service centers. The partnership, which has expanded to include 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 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.

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 2013 the population of this region will represent approximately 3.3 percent of the total Texas population. The largest ethnic minority group in this region is African American, projected to represent 18.2 percent of the total population in the region in 2013. The 2010 poverty rate for this region is estimated at 17.6 percent, which is slightly lower than the poverty rate for the state as a whole, which is estimated at 18.4 percent in 2010.

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 HHSC initiative, HHSC has delegated daily management of the initiative to the Department of Aging and Disability Services (DADS), through HHS System Circular-002: The Promoting Independence Initiative and Plan. Executive Order GWB 99-2 required that a report be submitted to the Governor's Office by January 2001, making recommendations regarding services for individuals with disabilities. HHSC established a statewide advisory committee to guide the development of this report, named the Texas Promoting Independence Plan.

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

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 TWC would cooperate to support the initiative and have staff participate on the committee. The latest plan is the 2010 Revised Texas Promoting Independence Plan—February 2011. A new plan will be submitted in December 2012, prior to the 83rd Legislative Session.

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 Supported Employment

DARS partners with community organizations and with other state agencies providing direct services related to long-term Supported Employment Services for persons with disabilities. Supported employment is competitive employment in an integrated work setting for consumers with the most significant disabilities who need extended services (at or away from the worksite) to maintain employment following Vocational Rehabilitation (VR) case closure. Collaboration is key to successful long-term employment outcomes. DARS has a Memorandum of Agreement (MOA) with DADS, effective through September 30, 2012, which defines the coordination of provision of employment services to individuals receiving services from DADS who may also be eligible for VR services from DARS. The MOA is being updated to include an annual exchange of data about individuals receiving services from both Departments, and this exchange will assist in provision of individualized services and achievement of quality employment goals.

4.2.3 Office of Acquired Brain Injury

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

An acquired brain injury (ABI) is an injury occurring 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, and exposure to toxic substances, brain tumors, near-drowning, or other incidences depriving the brain of oxygen.

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

According to the Brain Injury Association of America, brain injury is the leading cause of death and disability in persons younger than 45 years old, occurring more frequently than breast cancer, acquired immunodeficiency syndrome (AIDS), multiple sclerosis, and spinal cord injury combined. Populations at highest risk for brain injury are infants and children from birth through 4 years of age, adolescents (predominantly male) 16 to 25 years of age, and adults older than 65 years of age. The Centers for Disease Control and Prevention report that more than 155,000

Texans sustain a brain injury each year. More than 550,000 Texans are known to have a disability due to a brain injury.

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 to working with veterans with TBI, posttraumatic stress disorder (PTSD), 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; and
- Web-based continuing education courses for public health workers, law enforcement, consumers, and professionals.

4.2.4 Family-Based Alternatives

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

Administered by HHSC, the project assists institutionalized children in returning home to their birth families with support. When 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.

4.2.5 Community Resource Coordination Groups of Texas

Community Resource Coordination Groups (CRCGs) originated with S.B. 298, 70th Legislature, Regular Session, 1987, which directed state agencies serving children to develop a community-based approach to improve coordination of services for children and youth who have multi-agency needs and require interagency coordination. More than 160 CRCGs now exist. HHSC provides state-level coordination of CRCGs.

S.B. 1468, 77th Legislature, Regular Session, 2001, broadened the charge to include the adult population. Some communities have added the capacity to serve adults by expanding the current CRCG for children and youth, thus becoming a CRCG for families. Other communities have 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 HHS System consumers. The groups can include representation from the HHS system agencies, the criminal or juvenile justice system, the education system, housing agencies, the workforce system, local service providers, and families.

Local CRCGs are not directly funded by federal or state dollars and depend on agency coordination and support or resources from other organizations.

Mental health care is the most frequently identified service need for children and youth referred to local CRCGs. During 2009, about 74 percent of these referrals related to skill development issues, such as social skills, challenging behavior, or anger management. In addition, 52 percent related to mental health care services, and 51 percent were for life skills training. 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.

4.2.6 Task Force for Children with Special Needs

The Task Force for Children with Special Needs was established by S.B. 1824, 81st Legislature, Regular Session, 2009, and is overseen by the Governor's Office and administered by HHSC. The Task Force is an 18-member committee comprised of 4 legislators, key leaders from 9 state agencies, 3 consumers/advocates, and 1 representative from a local authority for people with intellectual disabilities. The Task Force includes eight statutorily-mandated subcommittees, focusing on: health, mental health, education, juvenile justice, crisis prevention and intervention, transitioning youth, long-term care, and early childhood intervention. By uniting

policy makers, agency leaders, disability advocates, consumers, and subject-matter experts, the Task Force is working to establish a joint vision for a system that better serves the needs of this population.

The mission of the Task Force is to create and implement a strategic plan to improve the coordination, quality, and efficiency of services delivered to children with chronic illnesses, intellectual and/or developmental disabilities, and/or mental illness. The Task Force completed and submitted its five-year plan to the legislature in October 2011, and it has focused implementation efforts into two areas. The first centers on strategies to prevent crisis and to intervene more effectively when crises occur. The second includes strategies to inform families better about special needs issues and options, and to provide them with tools and resources to improve their care-giving capacity through an array of avenues, from direct peer services to electronic information systems that include social media.

4.2.7 Texas Autism Research & Resource Center

Created by H.B. 1574, 81st Legislature, Regular Session, 2009, the Texas Autism Research & Resource Center (TARRC) is a program of DADS and HHSC. The TARRC's purpose 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 who 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 Center'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.

4.2.8 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 state 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. DADS 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 HHS System agencies and TEA 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 development of the TARRC website and a study to determine the costs and benefits of establishing a pilot program to provide services to adults with autism required by H.B. 1574 (81st Legislature, Regular Session, 2009).

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

4.2.9 Medicaid Infrastructure Grant—Mental Health Grant

The DARS Medicaid Infrastructure Grant (MIG) Program, in collaboration with all HHS agencies, promotes, facilitates, and increases competitive employment opportunities for working age Texans with disabilities. The Centers for Medicare and Medicaid Services awarded the Texas MIG an additional \$250,000 for grant year 2011 for the Department of State Health Services (DSHS) to modify Cognitive Adaptation Training (CAT), an evidence-informed practice. The grant will be used to enhance the DSHS Money Follows the Person Behavioral Health Pilot by adapting CAT to support employment of individuals who have transitioned from nursing facilities into the community, as well as those at potential risk for institutionalization. The adapted intervention will be tested, and a toolkit for employment for these populations will be developed based on the outcome of this intervention.

4.3 A Focus on Children

4.3.1 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. Four early childhood projects are in place to realize these goals: **Raising Texas** is a statewide interagency approach to improve the coordination of services for children birth to age five; **Healthy Child Care Texas** trains and certifies Child Care Health Consultants to improve health and safety in child care settings; and **Texas Home Visiting** and **Texas Nurse-Family Partnership** programs, described below.

4.3.2 Texas Home Visiting

The Texas Home Visiting Program was established in 2011 through a federal grant that extends through September 2016. The grant will support the development and implementation of home visiting programs and contribute to the development of a comprehensive early childhood system that promotes maternal, infant and early childhood health, development, safety, and strong parent-child relationships in Texas communities.

The Texas Home Visiting Program uses evidence-based home visiting program models to support a variety of outcomes. It serves to decrease domestic violence, child injury, emergency department use, and child maltreatment. Reducing these negative impacts helps to increase:

- Maternal and child health,
- School readiness and achievement,
- Family economic self-sufficiency, and
- Coordination and referrals for community resources and supports for families.

Participating communities are selected based on a county-level needs and capacity assessment that includes poverty, newborn health, child maltreatment rates, unemployment rates, longitudinal school drop-out rates, and substance abuse rates.

As of February 2012, nine counties have been selected to receive funding to develop early childhood community systems and develop or expand 28 evidence-based home visiting program sites.

4.3.3 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.

Under the TNFP, specially trained registered nurses regularly visit the homes of participating first-time mothers to provide support, education, and counseling on health, parenting, developmental issues, and life skills. Anticipated outcomes of the program include:

- Improved maternal outcomes,
- Improved child health and development,
- Increased self-sufficiency, and
- Reduced incidence of child abuse and neglect.

Thirteen existing TNFP sites, funded through general revenue and Temporary Assistance for Needy Families (TANF) funds, are expected to serve 2,025 clients in 2013. Five new sites funded through the Texas Home Visiting Program are expected to serve an additional 625 families.

4.3.4 Council on Children and Families

S.B. 1646, 81st Legislature, Regular Session, 2009, created the Council on Children and Families to coordinate the state's health, education, and human services systems for children and their families, and to prioritize and mobilize resources for children. The council is administratively attached to HHSC, but is independent in its direction. Council members include the chief executive officers, or designees of ten state agencies serving children, along with four public members appointed by the HHSC Executive Commissioner.

The Council is 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 methods to prevent unnecessary parental relinquishment of custody of children;
- Prioritizing assisting children in family settings rather than institutional settings; and
- Making recommendations about family involvement in the provision and planning of health, education, and human services for a child.

S.B. 717, 82nd Legislature, Regular Session, 2011, 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.

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 continue to be the 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.

4.3.5 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 that include the Texas Council on Family Violence, local CFRTs, the state-level CFRT, and DSHS. The CSRC meets quarterly, immediately before the state-level CFRT meeting. 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 on abuse and neglect for the medical community.

4.3.6 Psychotropic Medication Monitoring

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

Work related to children in foster care has included several efforts.

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

- **MEDNET Project**—The grant project entitled “Accelerating Utilization of Comparative Effectiveness Findings in Medicaid Mental Health” was developed to support evidence-based use of psychotropics in Medicaid, and includes six other state Medicaid programs (California, Maine, Missouri, New York, Oklahoma, and Washington) that collectively account for 33 percent of Medicaid enrollment nationally. Under the grant, Rutgers University will work with an existing network partnership, the Network for Evidence Based Treatment (NET) to create a consortium focused on increasing the utilization of evidence-based clinical and delivery system practices in the provision of mental health treatment for beneficiaries of state Medicaid programs previously mentioned. Texas participates in the current network of states that will collaborate as sub-recipients of the grant under Rutgers, the “Medicaid Network for Evidence-based Treatment” or MEDNET. This project is a coordinated effort with DFPS, DSHS, and HHSC Medicaid and Health Policy and Clinical Services.

4.3.7 Texas System of Care Grant

Through a grant from the Substance Abuse and Mental Health Services Administration, HHSC and agency partners are developing a statewide strategic plan to expand the federally-endorsed system of care model for children and youth with serious emotional disturbances and their families. HHSC is working with three communities to help inform the planning and preparations for improving cross-agency service delivery and community readiness to expand this model. The plan will be completed by the end of September 2012.

4.4 Councils, Committees, and Task Forces

The HHS 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 Texas Coordinating Council for Veteran’s Services

The Texas Coordinating Council for Veterans Services was created by S.B.1796 82nd Legislature, Regular Session, 2011, to continue the work of the Mental Health

Transformation Workgroup subcommittee on veterans' issues. The Texas Veterans Commission estimates that there are more than 1.8 million veterans in Texas. Six coordinating workgroups focus on specific issues affecting veterans, service members, and their families:

- Health and Mental Health,
- Criminal Justice,
- Higher Education,
- Housing,
- Employment, and
- Women Veterans.

In addition to compiling an inventory of veteran services provided by state agencies, the workgroups will identify the strengths and weaknesses of veteran services provided by the State of Texas, and 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 into a report, due October 1, 2012 and every even-numbered year thereafter, presenting findings and recommendations to the Governor and Legislature on improving services to Texas veterans.

4.4.2 Aging Texas Well Advisory Committee

The Aging Texas Well Advisory Committee is mandated by Executive Order RP-45 and advises and provides feedback to DADS in developing the Aging Texas Well Plan, aging policy issues, state government readiness and community preparedness. The committee is made of members from various stakeholder organizations and many state agencies, including the HHS System agencies, TWC, and the Texas Higher Education Coordinating Board. Some of the key activities for the committee are:

- Supporting initial rollout of the community assessment tool protocol pilot project,
- Providing technical assistance on research topics and state agency readiness,
- Sharing insights gained in the field by committee members, and
- Supporting other resource development as appropriate.

4.4.3 Texas Healthy Babies Expert Panel

The Texas Healthy Babies Expert Panel is made up of approximately 60 multi-disciplinary members representing various facets of maternal and child health. The panel meets biannually to provide guidance and support to the initiative. Professional organizations, advocates, hospitals, the HHSC, other health and

human service agencies, physicians, nurses, midwives, public health departments, schools of public health, medical schools, insurance companies, faith-based organizations, and the military are some of the areas represented.

4.4.4 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 health care 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 also has statutory oversight of the Health Professions Resource Center and the Texas Center for Nursing Workforce Studies, and has two statutorily mandated advisory committees, the Texas Center for Nursing Workforce Studies Advisory Committee and the Health Information Technology Advisory Committee.

4.4.5 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 for refining the educational requirements for certification and maintaining certification as EMS personnel and developing EMS and trauma care systems.

4.4.6 Public Health Funding and Policy Committee

The Public Health Funding and Policy Committee was established in accordance with S.B. 969, 82nd Legislature, Regular Session, 2011. 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.

4.4.7 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. 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.

4.4.8 Drug Demand Reduction Advisory Committee

S.B. 558, 77th Legislature, Regular Session, 2001, 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.

4.4.9 Local Authority Network Advisory Committee

The Local Authority Network Advisory Committee was established pursuant to requirements of H.B. 2439, 80th Legislature, Regular Session, 2007. The committee advises HHSC and DSHS on technical and administrative issues that directly affect local mental health authority responsibilities, including contracting methods that are flexible, responsive to the needs and services of local communities, and fulfill DSHS performance expectations. The committee reviews and makes recommendations regarding current and proposed rules, participates in the negotiated rulemaking

process related to local mental health authority operations, coordinates with workgroups affecting local mental health authority operations, and submits quarterly reports to HHSC and DSHS on its activities and recommendations.

4.4.10 Coordinated Chronic Disease Prevention Executive Steering Committee

The Coordinated Chronic Disease Prevention Executive Steering Committee addresses the Coordinated Chronic Disease Prevention, Health Promotion Program and the Community Transformation Grant Program called Transforming Texas. The committee provides direction, guidance, and oversight to these new major chronic disease prevention initiatives, including linkages to appropriate components of DSHS and HHSC. Committee members will have the opportunity to contribute to the development of a Coordinated Chronic Disease State Plan for Texas.

4.4.11 Texas Diabetes Council

Established by the Legislature in 1983, the Texas Diabetes Council works with private and public health care 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.

4.4.12 Chronic Kidney Disease Task Force

Established by the Legislature in 2007, the Chronic Kidney Disease (CKD) Task Force focuses on coordinating implementation of a state plan for prevention, early screening, diagnosis, and management of CKD, and educating health care professionals on the use of clinical practice guidelines related to CKD.

4.4.13 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.

4.4.14 Interagency Obesity Council

S.B. 556, 80th Legislature, Regular Session, 2007, created the Interagency Obesity Council 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.

4.4.15 Worksite Wellness Advisory Board

The Worksite Wellness Advisory Board was established by H.B. 1297, 80th Legislature, 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 used by the private sector for worksite wellness programs and worksite wellness features and architecture for new state buildings.

4.5 Operational Coordination and Process Improvements

4.5.1 Historically Underutilized Businesses Plan

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

4.5.2 Telework, Mobile Work, and Alternative Officing

Increasingly over the past 20 years, telework has been demonstrated by private and public sector organizations to achieve cost savings by increasing worker productivity and reducing office space. Also cited is the advantage of meeting the expectations of an evolving, technologically sophisticated workforce more concerned with production than commuting. At the national level, the Telework Enhancement Act of 2010, signed into law in December 2010, requires each federal agency to establish a policy that determines employee eligibility to participate in telework. Use of telework at Texas agencies and higher education institutions is increasing, according to the

Texas Comptroller of Public Accounts' 2010 report, "Analysis of Alternative Work Schedules," which documents a 15 to 20 percent growth over the past five years.

Traveling away from the office is the norm for a significant number of HHS employees, such as CPS workers, nursing home inspectors, food and drug inspectors, and child care licensing staff. Equipping these mobile staff with virtual access technology would mean more time being productive in the field and less time at the office. HHS would also see a decreased and more efficient space footprint—less dedicated office space for these staff, and more efficient common spaces (alternative officing) to support these mobile workers when they do need to use an office. In addition, virtual access technology means that select HHS jobs need not be done in agency offices—individuals could telework from home, decreasing the need for dedicated office space.

The HHS System Telework, Mobile Work, and Alternative Officing Project was established to assess the use of telework and mobile work at HHS agencies and the potential for the HHS System in strategically expanding its use, which could then reduce the need for leased space across the state. The workgroup scope includes staff and supervisor training, performance management, and technological and information security. HHS agencies are using the findings and recommendations from this project to ensure the appropriate conditions for a viable telework/mobile work strategy as they pilot or expand the use of telework and mobile work, and leverage the purchase power of the HHS system, to achieve efficiencies.

4.5.3 Health and Human Services System Contract Council

When the HHS agencies were consolidated in 2004, the HHS Contract Council was formed to improve contracting across the HHS System. The council includes the HHS agencies' chief operating officers and representatives from legal, finance, and programs with contracts, and it is responsible for developing a System-wide common perspective of contract management and implementing a contract management system.

In fiscal year 2010, the HHS agencies had 35,500 contracts that resulted in the procurement of more than \$26.6 billion in goods and services. These contracts range from administrative purchasing, for things such as office supplies, to payment for service provision in the Medicaid system. To make these procurements with accountability for taxpayers, different federal and state provisions require a variety of documents and processes. The Contract Council's constant challenge is to ensure contracting across the System is transparent, streamlined, and standardized where appropriate.

The Contract Council is developing a policy to allow interagency contracts to be signed using email approval. Scanning and email will also allow low risk contracts between HHSC agencies and contractors to be signed and sent via fax, scanning, or

email. This innovation will save time in approval processes and will save money on postage and handling costs.

The Contract Council will work on several issues during the strategic planning period of 2013-17.

- **Standardizing HHS Interagency Contract Templates**—Efficiencies can be gained by having one main template for use across all System agencies, with common terms and conditions, while also allowing slight variances to meet some agency-specific differences.
- **Assessing Renewal Processes**—The council is considering the opportunity for lengthening the terms of some contracts, so the workload of renewal would not have to be done every year. Renewals could take place every other year, or up to once every four years, for lower-risk contracts.
- **Developing a Policy for Using Electronic Documents**—This policy would allow certain faxed and scanned contracts to be accepted in lieu of printed copies, saving time for both contractors and agency staff.
- **Continuing to Explore Technology**—The council will investigate other opportunities to use technology to streamline the contract process, in particular the routing and signature process.

Each HHS 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.

4.5.4 Leadership Development

Effective leaders are developed and effective leadership is vital to the success and of any organization. DARS is partnering with the Health and Human Services Leadership Academy to engage selected staff in an intensive program of training, experiential activities, and professional mentoring designed to accelerate professional development. The Academy is designed to provide unique access to executive leadership across the HHS agencies and gives participants the opportunity to study the health and human services system from a macro level. Action learning is a central component of the program. Building leaders through the HHS System ensures a fundamental understanding of how the HHS agencies interact and create strategic ideas for further collaboration.

4.5.5 Survey of Employee Engagement

The Survey of Employee Engagement designed by and conducted under contract by 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 perceived various aspects of the workplace is critical to identifying and successfully implementing needed organizational changes. Data gathered over time provides additional insight into trends in employee perceptions. The summary of the survey responses, included in Appendix F, highlights survey results for the HHS System.

Chapter 5

Health and Human Services Commission External/Internal Assessment

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. In 2003, the 78th Legislature, Regular Session, 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 Health and Human Services (HHS) System consists of 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).

The remainder of this chapter is arranged as follows:

- Mission,
- External Assessment,
- Current Activities, and
- Internal Assessment.

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 Assessment

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 Ensuring Health Quality and Cost-Effectiveness

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

- Emphasize health promotion, primary care, disease prevention, and early intervention in a quality-oriented, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Work with partners to develop public health strategies to improve outcomes and to contain health care costs.

With guidance from Texas policy leaders and national experts, HHSC works to ensure the provision of quality 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 other providers are available to treat the growing Medicaid population.

Medicaid costs are the primary budget driver for HHSC, with client services costs in 2012 expected to be just under \$23 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 cost of care.

In state fiscal year (FY) 2011, caseloads reached more than 3.6 million, reflecting growth trends of 10 percent in 2010 and 7 percent in 2011. If upheld by the United States (U.S.) Supreme Court, federal health care changes enacted in early 2010 would add 1.8 million Texans to the Medicaid caseloads beginning in 2014.

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 fronts to improve quality and cost-effectiveness in Medicaid service provision.

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 U.S. Centers for Medicare & Medicaid Services (CMS) approved HHSC's application the following December. The waiver makes two major changes: restructuring the financing of health care for Medicaid-eligible patients and uninsured patients, and expanding Medicaid managed care to the entire state.

HHSC is also considering and adopting a wide variety of accountability structures to decrease the number of, 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

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, 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 Transformation Waiver provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds through a program and process that is transparent and accountable for public 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 will 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 a Regional Healthcare Partnership (RHP), to coordinate decision-making for how each region chooses to design and implement its innovations. The RHPs include public hospitals, public health care districts, health providers, and/or other stakeholders in a given region. RHPs reflect existing delivery systems, patient flow, and geographic proximity. An anchoring entity, usually a public hospital, coordinates stakeholder engagement and the development of an RHP plan. The anchor may also 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 (IGT) entities** are public hospitals or other governmental entities that may contribute public funds to draw down federal matching funds under the waiver. IGT entities will select DSRIP projects from a menu, determine estimated funding for each project, identify performing providers to implement those projects, and provide funding. Certain entities, such as public hospitals, may serve as both an IGT entity and a performing provider. Allowing IGT entities to participate in more than one RHP is particularly important for specialty providers—such as children’s hospitals or burn care—that may serve more than one region.
- **Performing providers**, such as hospitals, community mental health centers, and physician practice plans, may receive waiver incentive payments if milestones are reached in accordance with an approved DSRIP project.

The RHPs will outline projects and estimated funding levels in plans for HHSC approval early in FY 2013. Once the RHP plans are approved, HHSC will submit them for CMS approval. Only projects selected from the DSRIP menu and included in an HHSC- and CMS-approved RHP plan qualify for DSRIP payments.

Funding Under the Waiver

Federal funds available under both UC and DSRIP require local or state IGT funds to draw down approximately 60 percent federal matching funds. For example, a public hospital with \$40 million IGT can receive approximately \$60 million in federal matching funds and then have a total of \$100 million to spend under UC or DSRIP.

In Demonstration Year (DY) 1, \$4.2 billion (all funds) is available to the state for UC and DSRIP, and in all other years, \$6.2 billion (all funds) is available—for a potential total of \$29 billion over five years. This is an increase of federal funds available to the state compared to the historic UPL program. For example, in FY 2011, UPL payments in Texas totaled \$2.8 billion (all funds). In DY 1, most funds can be directed towards UC, but by DY 5, funds for UC and DSRIP will be approximately 50-50.

DSRIP Projects

All DSRIP projects must demonstrate delivery system transformation or quality of care improvement. 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 available in the DSRIP menu and if the arrangement is outlined in an RHP plan approved by HHSC and CMS.

The DSRIP menu of projects is divided into four categories.

- **Infrastructure Development**, such as investments in technology, tools, and human resources;
- **Program Innovation and Redesign**, including the piloting, testing, and replicating of innovative care models such as telemedicine or a patient-centered medical home;
- **Quality Improvements**, hospital-specific interventions such as reducing potentially preventable hospital admissions and readmissions; and
- **Population-Based Improvements**, for hospitals to show community-wide outcomes, such as higher rates of immunization and lower rates of chronic diseases like diabetes.

Additional information and waiver updates can be found at the [Medicaid Transformation Waiver](http://www.hhsc.state.tx.us/1115-waiver.shtml) (<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

Both in Texas and nationally, the Medicaid program and the Children's Health Insurance Program (CHIP) have increasingly turned to managed care systems to deliver services more effectively. The traditional 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 that incur unnecessary costs. In a managed care program, a managed care organization (MCO) is paid a capped (or capitated) rate for each client enrolled, and the MCO has the incentive to have good health care delivered in the most

efficient way. HHSC is continuing to expand Medicaid managed care in Texas and expects more than three million clients in managed care by 2013.

HHSC continually monitors whether the MCOs are succeeding in their work. Savings due to switching 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, so that 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 of provider payment. HHSC researches more than 10,000 different prices for health care services, compares these prices to the private sector and Medicaid programs in other states, and identifies possible changes that will lower expenses. To identify wasteful spending in managed care, HHSC monitors how the MCOs are spending paid premiums. HHSC also studies patterns of procedure use by providers, 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 Quality: Quality Measurement and Reporting on Managed Care Organizations

Federal law requires state Medicaid programs to contract with external entities to help evaluate Medicaid, and HHSC contracts with the Institute for Child Health Policy (IHP) at the University of Florida for this purpose. IHP produces an annual report with data to support HHSC's efforts to ensure that managed care clients have access to timely and quality care, in each of the managed care programs. The results allow comparison of findings across MCOs in each program and are used to develop overarching goals and performance improvement projects for Medicaid and CHIP managed care programs.

HHSC will continue to improve the quality of care for Medicaid and CHIP clients enrolled in participating health and dental managed care plans, through three quality initiatives.

- *The 5 Percent At Risk and Quality Challenge Program for Health and Dental Plans* places each plan at risk for up to five percent of their capitation payment, depending on the outcome of pre-identified performance measures. Any funds that are recouped are awarded to plans based on their performance, relative to each other, on a second set of quality metrics.
- *The Potentially Preventable Events Quarterly Report Series* assists with identifying health care expenditures and the factors contributing to potentially preventable admissions, potentially preventable readmissions (PPRs), and potentially preventable emergency room visits in the Texas STAR and STAR+PLUS Programs.

- *The Dual Eligible STAR+PLUS Focus Study* examines and continues to improve the quality of care for dual eligibles, people who are eligible for both Medicaid and Medicare, in the STAR+PLUS program.

Potentially Preventable Issues

For preventable adverse events, Texas Medicaid imposes the same reimbursement denials or reductions as does the federal Medicare program. HHSC also imposes payment denials/reductions for other adverse events after consultation with the state advisory committee on health care quality. Hospitals are required to submit present-on-admission indicators, and claims payment may be denied or reduced for conditions that were not present on admission. For claims with dates of admission on or after April 1, 2011, providers are required to notify HHSC or the Medicaid claims administrator when a wrong surgery or other invasive procedure is performed on a Texas Medicaid client. HHSC began imposing payment denials/reductions for these claims on September 1, 2010.

Potentially Preventable Complications

HHSC will begin communicating about potentially preventable complications to hospitals in September 2012, and payment reductions will begin in September 2013.

Potentially Preventable Events

HHSC will begin communicating about potentially preventable events (PPEs) to hospitals in September 2013, with payment reductions beginning in September 2014. PPEs occur when a client returns for hospitalization due to related deficiencies in care or treatment during the initial hospital stay or in follow-up care after the hospital stay. Some PPEs are:

- Readmission for the same condition or procedure,
- Infection or other complication resulting from care previously provided,
- A condition or procedure indicating that the previous admission's surgical intervention was unsuccessful in achieving the anticipated outcome, and
- Another condition or procedure of a similar nature.

Although PPEs are generally preventable, they will never be totally eliminated, even with optimal care. Therefore, proper risk adjustment and scoring is required in order to use PPEs in provider profiling and payments systems.

Potentially Preventable Readmissions

Consistent with House Bill (H.B.) 1218, 81st Legislature, Regular Session, 2009, HHSC implemented rules and business processes to support identification and reporting of PPRs. In January 2011, HHSC began applying PPR analytics to Medicaid-paid hospital claims. The analytics established state and hospital-specific PPR rates by disease condition and other variables. The information is provided to hospitals which are required to make this data available to the clinical staff working at the hospital. Hospitals received their first PPR report in January 2011 and their

second report in February 2012. Payment reductions related to PPR will begin in September 2012.

Non-Urgent Use of Emergency Department

On September 1, 2011, hospitals and physicians began receiving a 40 percent reduction for treatment of any non-emergent/urgent service rendered in the emergency room. Hospitals will continue to be reimbursed for the Emergency Medical Treatment and Labor Act (EMTALA) screen so that a client's medical status can be ascertained. If the EMTALA screen deems the client not emergent/urgent, the hospital/physician can opt to not treat the client.

The Physician Payment Committee

This committee was established by H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 68) to prevent payment for unnecessary services. The committee will determine the ten most overused services performed by physicians in Texas Medicaid, using national guidelines related to unnecessary medical procedures as the basis for this determination. Based on these determinations, HHSC will decrease Medicaid payments for those services that should not be provided. Physicians will maintain the right to appeal the decision in individual cases.

Maternity Care Management

The Maternity Care and Neonatal Intensive Care Unit (NICU) Care Management

This program provides care management for pregnant women with risk factors which could lead to complications and possible preterm labor. NICU Care Management works in conjunction with the Maternity Care Management program to provide services to families in the event the newborn is admitted into the NICU. NICU Care Management Services include educating families on the baby's medical progress and on the appropriate questions to ask the physician, and providing assistance to the family once the infant is discharged from the NICU. HHSC is working with the Medicaid claims administrator to implement this project by September 1, 2012.

The NICU Council was established by H.B. 2636, 82nd Legislature, Regular Session, 2011, to make recommendations to HHSC regarding NICU operating standards and reimbursement through the Medicaid program for services provided to an infant admitted to a NICU. Specifically, the council will:

- Develop standards for operating a NICU in Texas,
- Make recommendations regarding best practices and protocols to lower admissions to a NICU, and
- Develop an accreditation process for a NICU to receive reimbursement for services provided through the Medicaid program.

Induced Labor before 39th Week of Pregnancy

Effective October 2011, Medicaid stopped paying for elective inductions prior to 39 weeks of pregnancy, based on research and recommendations discouraging

elective inductions prior to 39 weeks gestation. HHSC also concluded that these elective inductions may contribute to avoidable NICU stays and Caesarean section births. This initiative was initially based on an HHSC Quality-Based Payment Committee recommendation to pursue improvements in birth outcomes and is consistent with H.B. 1983, 82nd Legislature, Regular Session, 2011. To ensure compliance with the new policy, while accommodating the allowed exception of medical necessity, the HHSC Office of Inspector General (OIG) conducted medical record reviews of claims for the first three months of the policy, October through December 2011. OIG reviewed claims that were billed with the modifier indicating that the delivery took place prior to 39 weeks gestation and was medically necessary. The OIG review indicated a high level of compliance with the new policy.

All Patient Refined-Diagnosis Related Group

Effective September 1, 2012 Texas Medicaid will transition to a new set of codes for billing structure, known as the All Patient Refined-Diagnosis Related Group (APR-DRG) structure for hospitals that are currently reimbursed under Medicare Severity-Diagnosis Related Group (MS-DRG). This methodology is based on a similar structure used as the basis for calculating inpatient hospital prospective payments for acute care hospitals. The APR-DRG methodology has several benefits:

- Encompassing all client populations,
- Allowing a higher level of specificity on inpatient hospital claims,
- Addressing patient severity of illness and patient risk of mortality in addition to patient resource intensity,
- Allowing HHSC to consider quality-of-care and pay-for-performance measures such as PPRs and potentially preventable complications, and
- Allowing providers to use additional procedure codes and diagnosis codes.

Hospitals (children's hospitals, rural hospitals, and teaching hospitals) that are currently reimbursed under the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), are tentatively scheduled to be moved to APR-DRG in September 2013.

Children's Increased Access to Vitamin and Minerals

The 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 72), requires vitamins and minerals to be added to the Medicaid Vendor Drug Program (VDP) formulary so that all VDP-enrolled pharmacies can be reimbursed for providing this benefit to children in the Comprehensive Care Program (CCP). Children can currently access medically-necessary vitamins and minerals through pharmacies that are enrolled in CCP. However, this change will allow a greater number of pharmacies across the state to participate and will increase children's access to vitamins and minerals. HHSC identified 26 vitamins and minerals that will be available to CCP children through VDP-enrolled pharmacies.

Senate Bill 7

Discussion

Senate Bill (S.B.) 7, 82nd Legislature, First Called Session, 2011, directs HHSC to make changes in policy and payment structure in a variety of ways.

Planned Actions

S.B. 7 Medicaid Reform Waiver

S.B. 7 directs HHSC to seek a federal waiver to increase flexibility in the way Texas operates its Medicaid program. HHSC will provide information and reform options for the S.B. 7 Legislative Oversight Committee's consideration, including:

- Eliminating or limiting retroactive eligibility coverage,
- Implementing cost sharing,
- Achieving greater flexibility in benefit design,
- Expanding the use of premium assistance,
- Exploring a tiered services system for long-term services and supports (LTSS) for individuals with intellectual and developmental disabilities,
- Expanding access to person-centered options for LTSS, and
- Developing a nursing facility quality incentives program.

Based on direction from the Committee, HHSC will submit a concept paper to CMS.

S.B. 7 Quality and Cost-Containment Initiatives

S.B. 7 established several other quality and cost-containment initiatives.

- **The Medicaid/CHIP Quality-Based Payment Advisory Committee** was established by S.B. 7 to advise HHSC on quality-based reimbursement systems and policies.
- **Electronic Visit Verification**—S.B. 7 directs HHSC to implement, if cost-effective and feasible, an electronic visit verification system to document health care providers' visits to the home setting. This system would be considered for nursing, personal care, and therapy services provided to children 21 years of age and younger in the home. A similar initiative at DADS is described in Chapter 6.
- **Medicaid Comprehensive Nursing Assessment**—S.B. 7 directs HHSC to develop an objective assessment process for determining the medical needs for nursing services in the home, such as therapy services, personal care services, or durable medical equipment. This comprehensive assessment would be required for people in the traditional Medicaid program, and managed care contracts will be updated as necessary to require the comprehensive nursing assessment.

Rider 61 Cost-Containment Initiatives

Discussion

Rider 61 of the General Appropriations Act also has had an impact in directing HHSC's health care innovations.

Planned Actions

The 2012-13 General Appropriations Act (GAA) directed the HHS agencies to save more than \$3 billion in general revenue for the 2012-13 biennium, including \$450 million savings from Rider 61, through initiatives that reward quality, improve health outcomes, establish efficient rates, encourage appropriate service use, and maximize funding from federal and other payers. Examples of these initiatives are listed here.

- To reward quality, HHSC is moving to an APR-DRG reimbursement system for inpatient hospital services, as described above.
- To improve health outcomes, HHSC ended Medicaid payments for elective deliveries occurring prior to 39 weeks, also described above, which is expected to reduce birth complications and improve birth outcomes.
- To establish efficient rates, HHSC has moved to a fee schedule for imaging services rendered by outpatient hospital providers and has reduced facility payments for non-emergency services delivered in an emergency department.
- To encourage appropriate service use, HHSC has reviewed and implemented limitations for selected medicine and medical supplies, and it is reviewing the amount, duration, and scope of other Medicaid services to achieve additional savings.
- To maximize other funding sources, HHSC received federal approval in April 2011 of a waiver that allows the state to receive increased federal financial participation for certain Medicaid medical transportation services. HHSC will seek to maximize co-payments in Medicaid and other programs; for example, CHIP co-payment increases took effect March 1, 2012.

Federal Health Care Changes

Note: At the time of publication, the U.S. Supreme Court had not ruled on the constitutionality of the Patient Protection and Affordable Care Act of 2010.

Discussion

The Patient Protection and Affordable Care Act enacted March 23, 2010, together with the Healthcare and Education Reconciliation Act of 2010 enacted March 30, 2010, are called the Affordable Care Act (ACA). If upheld by the U.S. Supreme Court and not repealed by Congress, the ACA would reduce uninsurance among Texans and make significant changes to the health care market. The most significant changes impacting Medicaid and CHIP would occur in 2014, with the

expansion of Medicaid, changes to the way eligibility is determined for the Medicaid and CHIP programs, and implementation of a Health Benefit Exchange.

HHSC has been working with other HHS System agencies to analyze the impact of ACA-required changes on current HHS systems and to plan for successful integration of changes to operating systems, automation, and other relevant program operations. In addition, HHSC has been coordinating with the Texas Department of Insurance on changes impacting both agencies.

HHSC tracks ACA-related grants of interest to HHS agencies and works with sister agencies on the application process. To date, DSHS has received 14 grants, DADS has received 6 grants, and HHSC has received 2 grants. These grants fund a variety of activities such as early childhood home visitation, chronic disease prevention, and tobacco prevention programs.

While most of the federal health care changes are scheduled for implementation in 2014, HHS agencies have been working toward implementing changes to comply with federal requirements with early effective dates. In 2010, HHSC began claiming federal matching funds for the children of public school and state employees who enroll in CHIP. Also in 2010, HHSC reinstated reimbursement for services to free-standing birth centers. In 2012, HHSC plans to add tobacco cessation counseling services for pregnant women and to contract with an audit company to recover overpaid claims to providers.

Planned Actions

HHSC is studying implementation of federal health care changes as described here.

To encourage greater provider participation in Medicaid, the ACA requires states to increase Medicaid reimbursement to designated primary care providers from January 1, 2013, through December 31, 2014. This rate change is to reimburse Medicaid physicians at Medicaid rates for certain primary care services. Federal law provides states with 100 percent federal match for the difference for these services between the state's Medicaid rate in effect in July 2009 and the 2013-14 Medicare rate.

If left in place, the ACA would significantly change the way eligibility is determined for Texas Medicaid and CHIP programs. Beginning January 1, 2014, the ACA would expand Medicaid eligibility to 133 percent of the federal poverty level (FPL) for non-pregnant individuals younger than age 65, and to individuals younger than age 26 who were formerly in foster care and on Medicaid. The ACA would also make the following changes to financial eligibility requirements in Medicaid and CHIP beginning in January 2014:

- Using modified adjusted gross income for parents, caretakers, pregnant women, children, and the newly eligible expansion adults (non-disabled, age 19-64, at or below 138 percent FPL);

- Eliminating all assets tests and income disregards (except for certain groups, such as individuals with disabilities); and
- Establishing a five percent income deduction allowance which effectively raises the Medicaid income ceiling from 133 percent FPL to 138 percent FPL.

To help cover the costs of the required Medicaid expansion, the ACA increases federal financial participation levels for both CHIP and Medicaid. In Texas, the increased federal financial participation for newly eligible adults in Medicaid is to be:

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

For CHIP, the federal financial participation increases by 23 percentage points each year from October 2015 through September 2019 (not to exceed 100 percent).

In addition to eligibility changes, states are to streamline and simplify eligibility and enrollment processes to achieve a “no wrong door” approach for people applying for insurance coverage, whether through Medicaid, CHIP, or premium assistance, through the Health Benefit Exchange (HBE). Each state is required to create an HBE. If a state chooses not to create an HBE, the federal government will create and administer the HBE for that state. States are to conduct outreach to enroll underserved populations in Medicaid and CHIP.

There would be a streamlined application process for individuals to apply for Medicaid, CHIP, or premium assistance under the HBE, through a variety of means, including a website. The state’s Medicaid and CHIP systems are to interface and exchange data with the HBE regarding eligibility for these programs.

The federal changes require that the new Medicaid expansion population receive a Medicaid benchmark benefit package of services, including the federally-defined essential health benefits. The benchmark plan must be actuarially equivalent to one of the following:

- Federal Employee Health Benefit Plan;
- State employee coverage;
- The health maintenance organization plan that has the largest insured commercial, non-Medicaid enrollment in the state; or
- Coverage approved by the Secretary of the U.S. Department of Health and Human Services.

Individuals younger than age 21 who are receiving coverage through a benchmark benefit must receive early and periodic screening, diagnosis, and treatment

(EPSDT) wrap coverage. Wrap coverage means that if a state applied a benchmark benefit (without EPSDT services) to a child population, it would still have to include (wrap) EPSDT coverage for that child population to have an acceptable benefit package for children that conforms with the law.

EPSDT requires states to provide comprehensive services to individuals younger than age 21 and to furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. This includes medically necessary services that exceed benefit limitations that the state may otherwise adopt.

Elimination of Disproportionality and Disparities

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

- Emphasize health promotion, primary care, disease prevention, and early intervention in a quality-oriented, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Improve access to effective behavioral health, prevention, and treatment services.
- Work with partners to develop public health strategies to improve outcomes and to contain health care costs.
- Ensure programs and initiatives recognize and address health disparities and disproportionality to improve outcomes across all programs.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Engage communities in developing service delivery systems, programs, and policies.

Strategic Priority: Ensure good outcomes in all health and human services programs by strengthening and supporting the workforce, infrastructure, technology, and integrity in business processes.

- Use technology to maximize work efficiency and eliminate costly maintenance and repair on unneeded and underutilized office space.
- Encourage innovation and teamwork.

Discussion

People in different race/ethnic groups experience different rates of disease and different rates of involvement with public assistance and public safety programs. For example, Hispanics and African Americans experience higher levels of chronic

illnesses such as cardiovascular disease and diabetes, and African-American children are over-represented in the group of children who are in the Child Protective Services program and awaiting adoption.

The Center for the Elimination of Disproportionality and Disparities (CEDD) was created by S.B. 501, 82nd Legislature, Regular Session, 2011 to help address disproportionality and disparities in Texas health and human services. S.B. 501 established the center as the State Office of Minority Health to assume a leadership role in working with state and federal agencies, universities, private groups, communities, foundations, and offices of minority health to decrease or eliminate health and health access disparities among racial, multicultural, disadvantaged, ethnic, and regional populations.

S.B. 501 provides for a comprehensive approach and allows Texas to maximize resources and produce better results through the development of recommendations for strategies that cut across every system that contributes to disproportionality and disparities for the same populations.

The CEDD serves as a leader in addressing the systemic factors and identifying practice improvements that address the disproportionate representation and disparate outcomes for children, their families, and other vulnerable citizens within Texas Health and Human Services systems.

Planned Actions

Training and Technical Assistance

Teach systems to use data to identify disproportionality and to set improvement goals.

- Create learning resources—webinars, conferences, symposia.
- Conduct Institute trainings.
- Provide assistance to systems, organizations that require assistance and support to address this issue.
- Build capacity for training and technical support to contracted providers around cultural competency.
- Offer consultation/support for other systems.

Leadership Development

- Train in courageous conversations about race.
- Discuss the barriers and challenges of disproportionality work.
- Use Undoing Racism© as a foundational piece from which additional training occurs.
- Conduct internal and external organizing for disproportionality work.

Innovation

- Create a think tank on disproportionality.
- Create and disseminate best and promising disproportionality practices and models such as family-focused practice.
- Develop disproportionality tools on how to assess clients.
- Provide models for improving community engagement.
- Develop a model/guide to address disproportionality in systems (identify the rules).

Media and Marketing

- Create and maintain an interactive website.
- Develop disproportionality social marketing/awareness campaigns.
- Create and give awards for disproportionality work.
- Create a speakers bureau.

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, primary care, disease prevention, and early intervention in a quality-oriented, 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.

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

Discussion

The Texas Integrated Eligibility Redesign System (TIERS) is the new automated system that caseworkers use to determine whether applicants are eligible for benefits. In 2011, the TIERS system was implemented statewide. The completion of the TIERS rollout provides opportunities to improve efficiency and increase integrity using technology.

HHSC is modernizing the current eligibility system to reduce the demand on eligibility staff resources, ensure efficiency with taxpayer resources, and facilitate client access to information about their case. The agency is identifying initiatives to

use technology to meet the forecasted growth in client caseload and improve eligibility business processes over the next several years. Research shows that clients have access to and are using technology. The Pew Internet and American Life Project reports that in 2011, 62 percent of Americans with an income less than \$30,000 had access to the Internet. That number is expected to increase annually.

Increasing self-service options improves business processes for both the clients and staff. Client ability to apply for and access benefit information electronically at the website www.yourtexasbenefits.com empowers clients to manage their case outside of traditional office hours. Client use of the website also saves staff time on data entry, processing, and responding to routine inquiries about their cases. These increased efficiencies will reduce use of overtime and will help enable staff to meet growing caseloads and workload demands.

At www.yourtexasbenefits.com clients currently can handle a variety of functions:

- Prescreening to learn if they are eligible for benefits,
- Creating an account,
- Submitting a new application,
- Viewing case details,
- Updating address/phone information,
- Printing temporary Medicaid Identification cards, and
- Reporting changes.

By 2013, clients will be able to handle other functions, too:

- Submitting re-determinations,
- Viewing correspondence online,
- Opting out of paper notifications to receive all communications electronically, and
- Uploading documents.

Planned Actions

The www.yourtexasbenefits.com site will continue to be enhanced during the strategic planning period of 2013-17 as additional technology becomes available. HHSC has identified strategies to increase the number of client transactions conducted through the Internet.

Two different initiatives deserve particular description.

Computers and Assistance in Local Office Lobbies

To facilitate use of www.yourtexasbenefits.com and increase client awareness, computers are being placed in the lobbies of HHSC offices. Staff assist clients using

the website and educate them about functionality of the system. Lobby computers will be installed in a majority of offices by FY 2013.

Partnering with Community-Based Organizations

Many Community-Based Organizations (CBOs) already provide information about HHSC programs and help clients apply for benefits as part of their mission. The online electronic applications allow CBOs to more fully serve their client base that need HHSC program services. HHSC is partnering with CBOs to increase community access points with geographic convenience for clients seeking or managing HHSC program benefits.

There will be three levels of partnership, and an organization can select the level that best meets their needs. These levels range from having a computer for clients or applicants to use, providing assistance in completing and application or managing their case, or receiving client authorization to access information on the client's behalf. The faith- and community-based organizations that partner with HHSC will be able to access reports on the number of clients they assist. HHSC partners provide valuable feedback on how to improve the benefit process for clients. Through client education and assistance, community partners increase client comfort with using www.yourtexasbenefits.com.

In FY 2013, it is anticipated that the program will expand statewide to all organizations interested in becoming a Community Partner. As participation in the Community Partner Program grows throughout Texas from FY 2014 through FY 2017, HHSC will ensure the tools and support provided to Community Partners are sufficient to help clients effectively apply for and manage their HHSC-administered benefits. Such tools and support include the following:

- Web-based training and instructor-led training, as needed;
- Updated communication and revised web-based training as HHSC introduces new web site features;
- Technical assistance with using the website, and understanding the application process;
- Provision of Community Partner reports; and
- Development of a web-based searchable database of available Community Partners.

CBO partners are an essential element of HHSC's meeting the demand for eligibility determination with innovation and technology, 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 partnerships with individuals, families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Work closely with faith- and community-based organizations to assist people in applying for nutrition, medical, and monetary assistance, and other service needs.

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 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.

In FY 2010, HHSC implemented a program change, with federal approval, to allow a limited number of community partners from the Texas Food Bank Network to conduct the Supplemental Nutrition Assistance Program (SNAP) interview requirement, and to provide outreach and application assistance. This innovative model of partnership continues to achieve results, and provides enhanced service and convenience to HHSC clients. HHSC expects to continue to partner with food banks to serve HHSC clients.

Additionally, 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, a number of 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, several specific actions are planned to strengthen community partnerships in this strategic planning time period.

As noted in the previous section, HHSC is developing a program to partner with organizations that provide information about HHSC programs and help clients apply for and manage their HHSC-administered benefits. These partnerships will increase access points for clients and build partnerships between HHSC and local organizations. It is anticipated that HHSC will receive critical feedback from partners that will help strengthen the website and communication materials for use in the community partner 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 are working to improve partnerships on several fronts:

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

Enhanced Contract Support

HHSC has begun to host a series of webinars with community partners to increase their understanding of other HHSC and HHS agencies' programs. To date, these webinars have featured primarily HHSC programs. Because these webinars have been well-received, HHSC will expand the programming.

HHSC also anticipates concluding the redesign of two key data collection and reporting systems in FY 2013. The redesign of the systems will not only ensure compliance with federal security and reporting requirements, but will also increase the flexibility and ease-of-use for HHSC program partners.

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.

Expanded Scope of Authority

Discussion

OIG is adapting its work to take into account new circumstances that have occurred. With the recent expansion of Medicaid managed care and the passage of other health care legislation, the landscape of Texas Medicaid has undergone considerable change. Additionally, the expanded scope of OIG's investigational authority over State Mental Health Hospitals (SMHs) adds a new dimension to OIG's responsibilities. OIG remains committed to fulfilling its critical role in the HHS System by providing expertise, assistance, and high-quality policy and process recommendations to HHS 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.

On March 1, 2012, HHSC implemented changes to the delivery of Medicaid and CHIP services. These changes include the expansion of the STAR and STAR+PLUS Medicaid managed care programs to new areas of the state and the transition of approximately 880,000 people from the Primary Care Case Management (PCCM) program into managed care. Additionally, prescription drug benefits, currently administered through HHSC's Vendor Drug Program, are now primarily delivered through the Medicaid and CHIP MCOs. These changes have

resulted in managed care now being the primary vehicle by which almost all Medicaid recipients obtain access to care from providers.

This large-scale expansion of managed care and transition from a fee-for-service environment presents a unique set of challenges for OIG. First, OIG must marshal and restructure its existing resources in order to effectively identify and interdict fraud, waste, and abuse within the myriad of MCOs and providers while maintaining credibility as an effective investigative and deterrent force. Second, OIG must access data and identify areas of risk where OIG has not traditionally operated, to ensure appropriate oversight of the MCOs' delivery of adequate health care and their compliance with applicable federal and state laws and contractual requirements.

Planned Actions

- OIG will double the size of its Medicaid Provider Integrity enforcement section to enhance its investigative efforts of MCOs and providers.
- OIG will integrate its investigative and enforcement efforts with those of MCOs to provide efficient and rapid case investigations and recoveries.
- OIG will establish cooperative processes and procedures with MCOs, including regular training so that MCOs understand and are proactive in preventing, detecting, and recovering fraud, waste, and abuse.
- OIG will establish a Managed Care Audit Unit that will conduct comprehensive, risk-based audits of MCOs, detect fraud, waste, and abuse within these entities, as well as identify issues of compliance with federal and state law and contractual requirements.

Integration of Federal Medicaid Changes

Discussion

In March 2010, the ACA 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;
- 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 S.B. 223 and H.B. 1720 with an effective date of March 23, 2012.

OIG is tasked with ensuring compliance with the new federal requirements and state legislation, as well as coordinating their program integrity provisions as they apply both to fee-for-service and managed care providers. Additionally, the ACA requires all existing providers to re-enroll, thus increasing the number of provider enrollment screenings and on-site inspection visits conducted by OIG.

Planned Actions

- OIG will participate on several HHS workgroups related to ACA implementation.
- OIG will draft new rules that incorporate the new provider screening and enrollment requirements.
- OIG will draft a new provider disclosure form that will capture all of the new disclosure requirements.
- OIG will conduct unscheduled on-site inspection visits for medium and high-risk providers as part of the enrollment process.
- OIG will modify its recipient fraud investigations to reflect the new eligibility criteria.
- OIG will suspend payments to providers upon verification of a credible allegation of fraud.

Contracts with External Stakeholders Related to Fraud, Waste, and Abuse in State Supported Living Centers and State Mental Health Hospitals

Discussion

The U.S. Department of Justice has mandated that Texas address allegations of criminal activity by licensed clinical staff at all SMHHs and State Supported Living Centers (SSLCs). Accordingly, the Legislature passed S.B. 643, 81st Legislature, Regular Session, 2009, which granted OIG the authority to investigate alleged criminal offenses at these facilities. This has resulted in a change to the current Memorandum of Understanding (MOU) between OIG and DADS, DSHS, DFPS, and the Office of Independent Ombudsman for SSLCs. The MOU now provides that all criminal allegations of abuse, neglect, and exploitation at these facilities will be referred to OIG for investigation.

OIG anticipates that this expanded scope of responsibility will result in more than 600 additional cases for investigation each year.

Planned Actions

- OIG will collaborate with DADS to establish a protocol for referring all allegations involving SSLC licensed, professional staff.
- OIG will establish a separate investigative unit that will be specifically tasked with investigating criminal allegations at all SMHHs.

5.4 Current Activities

HHSC has two very different kinds of responsibilities: oversight of the HHS System (Goal 1 in the appropriations bill pattern) and direct provision of services (Goals 2 through 4). All these responsibilities are described below.

5.4.1 HHSC Goal 1: HHS Enterprise Oversight and Policy

HHSC is accountable to Texans for ensuring that the consolidated HHS System agencies provide quality services as efficiently and effectively as possible. As indicated by this Coordinated Strategic Plan and agency Strategic Plan, HHSC fulfills this role by providing oversight and operational support in a variety of ways.

As part of the responsibilities under Goal 1, HHSC is responsible for the following activities:

- Coordinating and monitoring the use of state and federal money received by HHS agencies;
- Reviewing state plans submitted to the federal government;
- Monitoring state health and human services agency budgets and programs, and making recommendations for budget transfers;

The agency conducts research and analyses on demographics and caseload projections, and directs an integrated planning and budgeting process across the five HHS agencies.

HHSC provides the leadership to assist the HHS agencies in developing customer-focused programs and policy initiatives that are relevant, timely, and cost-effective. HHSC ensures that state and federal funds allocated to HHS agencies are coordinated and monitored, and spent in the most efficient manner.

Special Initiatives

Texas Institute of Healthcare Quality and Efficiency

The Legislature established the Texas Institute of Healthcare Quality and Efficiency (the Institute) during the 82nd Legislature, First Called Session, 2011, to improve health care quality, accountability, education, and cost containment by encouraging provider collaboration, effective delivery models, and coordination of services. The Institute has a wide scope, encompassing the broader health care system in Texas, including Medicaid and CHIP. The Institute is charged with making legislative recommendations in three key areas:

- Improving quality and efficiency of health care delivery;

- Improving reporting, consolidation, and transparency of health care information; and
- Implementing and supporting innovative health care collaborative payment and delivery systems.

Organizationally, the Institute is administratively attached to HHSC within the Office of Health Policy and Clinical Services.

Within this overarching framework, the Institute will study and issue recommendations on various aspects of health care:

- Quality-based payment systems that align payment incentives with high-quality, cost-effective health care;
- Alternative health care delivery systems that promote health care coordination and provider collaboration;
- Quality of care and efficiency outcome measurements that are effective measures of prevention, wellness, coordination, provider collaboration, and cost-effective health care;
- Improvements related to the reporting of health-related data collected by the state that reduce administrative burdens associated with reporting, while increasing consumer access to and use of data; and
- Methods to evaluate health care collaborative effectiveness.

The Institute draws expertise from a governor-appointed Board of Directors that is composed of health care providers, payors, consumers, and health care quality experts, in addition to representatives from several state agencies. HHSC has also established an Executive Steering Committee of the HHS System agencies to support the Institute in a coordinated and collaborative manner across the HHS System.

Center for the Elimination of Disproportionality and Disparities

Pursuant to S.B. 501, 82nd Legislature, Regular Session, 2011, the Center for the Elimination of Disproportionality and Disparities (CEDD) assists HHS 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 CEDD Director serves as the presiding officer for the legislatively mandated Interagency Council on Addressing Disproportionality and Disparities. With administrative support from the CEDD, the council examines the level of disproportionate involvement of children who are members of a racial or ethnic minority group at each stage in the juvenile justice, child welfare, and mental health systems. The work takes diverse forms along the paths of various programs.

- Investigate and report on issues related to health and health access disparities among racial, multicultural, disadvantaged, ethnic, and regional populations.
- Develop short-term and long-term strategies to eliminate health and health access disparities among racial, multicultural, disadvantaged, ethnic, and regional populations.
- Monitor the progress of each health and human services agency in eliminating health and health access disparities.
- Advise each health and human services agency on the implementation of any targeted programs or funding authorized by the legislature to address health and health access disparities.
- Consult with each health and human services agency.

As the State Office of Minority Health, the CEDD works with internal and external stakeholders to provide technical assistance and resources for initiating and augmenting efforts to address disparities at the state, regional, and local levels.

5.4.2 HHSC Goal 2: Medicaid

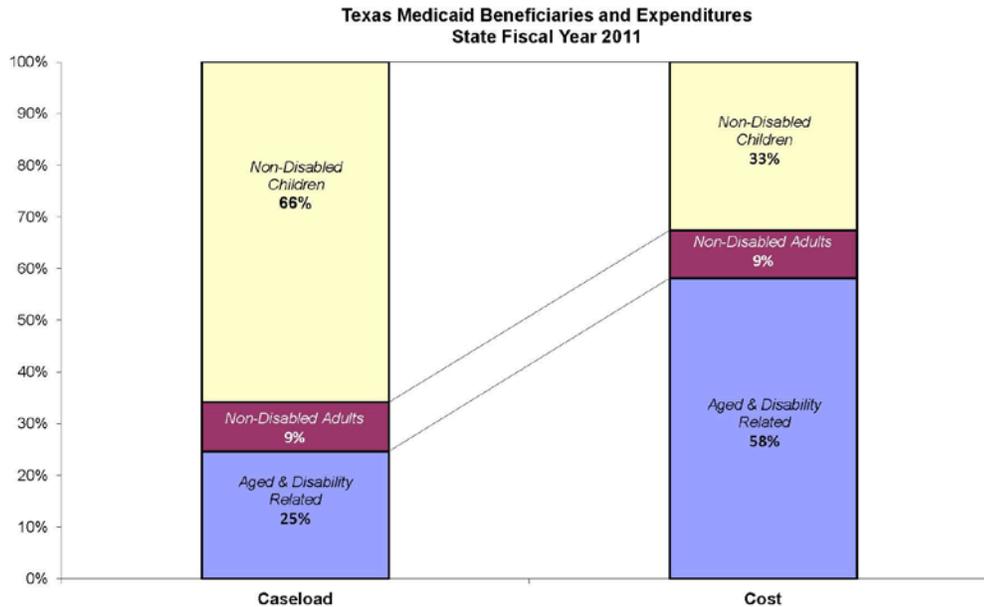
Target Population

Medicaid serves low-income families, children, related caretakers of dependent children, pregnant women, older persons, and people with disabilities. Initially, the program was only available to people receiving 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 persons, people with disabilities, children, and pregnant women).

Children comprise the majority of Medicaid recipients but account for a relatively small portion of the expenditures. By contrast, the aged and people with disabilities make up just 25 percent of recipients, but account for 66 percent of Texas Medicaid spending on direct health-care services. Figure 5.1 illustrates the percentages of the Medicaid population by client category and the portion of the Medicaid budget spent on each group in FY 2010.

The largest portion of the Medicaid population consists of women and children. As of August 2011, out of a total enrollment of 3,653,205, about 54 percent of the Medicaid population was female, and 76 percent was younger than 19 years of age. These groups are more likely to meet the eligibility criteria established for TANF, which provides them with automatic Medicaid eligibility. Medicaid eligibility is determined first, and eligibility for other programs is determined subsequently.

Figure 5.1
Medicaid Beneficiaries and Expenditures, Fiscal Year 2011



Source: HHS Financial Services, 2009 Medicaid Expenditures, including Acute Care, Vendor Drug, and Long-Term Care. Costs and caseload for all Medicaid payments for full beneficiaries and non-full beneficiaries (Women's Health Waiver, Emergency Services for Non-Citizens, Medicare payments) are included. Children include all Poverty-Level Children, including TANF. Disability Related Children are not in the Children group.

Figure 5.1: HHSC Financial Services, June 2012.

The Social Security Administration (SSA) determines eligibility for SSI, the federal program that provides direct financial payments to low-income persons who are older, blind, or have disabilities. All SSI recipients in Texas are also categorically eligible for Medicaid, and they automatically receive Medicaid upon SSI determination. In Texas, DARS 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 5.2 shows the number of Medicaid enrollees for selected fiscal years. From FY 2004 to FY 2011, the average monthly enrollment in the Medicaid program grew from 2.6 to 3.5 million, an increase of approximately 35 percent.

Figure 5.2
Texas Medicaid Enrollment, Fiscal Years 2004-11

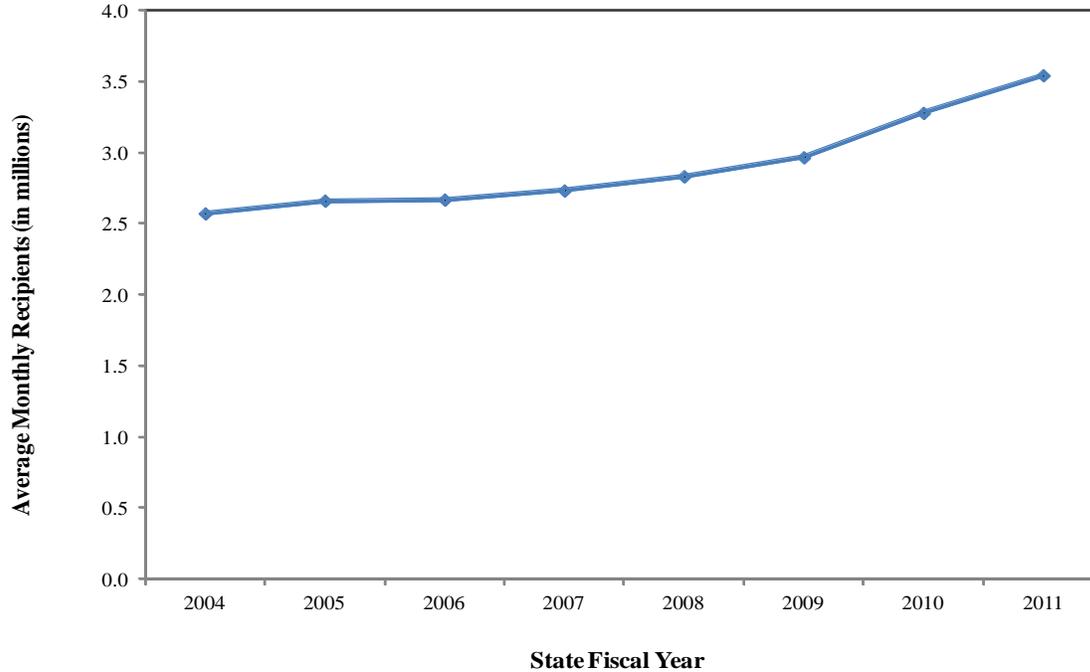


Figure 5.2: Health and Human Services Commission - Strategic Decision Support, March 2012.

Research also shows that the number of Texans in key program categories who could be potentially eligible to receive Medicaid benefits is expected to continue growing. The Medicaid eligible population is also projected to continue growing from 2013 to 2017. These numbers do not include people who would be eligible under the federal expansion of coverage.

- The number of qualified pregnant women older than 18 and younger than 45 and living at or below 185 percent of poverty for at least one month of the year will grow from 234,000 in 2013 to 250,000 in 2017, a 7 percent increase.
- The number of infants at or below 185 percent of poverty for at least one month of the year will grow from 314,000 in 2013 to 319,000 in 2017, a 2 percent increase.
- The number of children 1 to 5 years of age who are at or below 133 percent of poverty for at least one month of the year will grow from 1,448,000 in 2013 to 1,492,000 in 2017, a 3 percent increase.

- The number of children 6 to 18 years of age who are at or below 100 percent of poverty for at least one month of the year will increase from 2,136,000 in 2013 to 2,287,000 in 2017, a 7 percent increase.

Disability

As of August 2011, approximately 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 65 years of age or older also have a disability.

Gender

As of August 2011, females made up 54 percent of Medicaid clients. Texas Medicaid recipients are disproportionately female, for several reasons.

- Women live longer, on average. In 2011, 56 percent of the population 65 years of age or older was female.
- TANF beneficiaries are typically single-parent families, and in Texas, 93 percent of single-parent families receiving TANF are headed by females. Additionally, in 2010, 33 percent of single-parent families headed by a female lived below the poverty line, as compared to eight percent of two-parent families.
- Medicaid covers eligible low-income women for pregnancy-related services.

Age

As of August 2011, children younger than 19 years of age and persons 65 years and older made up 83 percent of all Medicaid enrollees. Children younger than 19 years of age comprise 76 percent, or 2,792,106 of the 3,653,205 persons enrolled in the program as of August 2011. This figure includes children younger than 19 years of age who also received SSI benefits due to a disability.

Ethnicity

Hispanics represented the largest proportion of Medicaid clients, comprising 52 percent of the Medicaid population in Texas, followed by Anglos (21 percent), and then by African Americans (17 percent). In 2011, the state's population composition according to race/ethnicity was as follows according to the Texas State Data Center: 44 percent Anglo, 39 percent Hispanic, and 12 percent African American. All other population groups, combined, comprised the remainder.

Service Description

Medicaid is a means-tested entitlement program financed jointly by the state and federal governments and administered by the state. Medicaid pays for basic health care (physician, inpatient, outpatient, pharmacy, lab, and X-ray services). Medicaid

also covers long-term care services and supports for older adults and recipients with disabilities. In August 2011, approximately one in seven Texans relied on Medicaid for health insurance or long-term care services and supports. As a result, the Medicaid program is the state's largest HHS System program.

The bulk of the federal share of the jointly financed Medicaid program is determined based on a formula that takes into consideration the average state per capita income compared to the U.S. average. This is specifically known as the Federal Medical Assistance Percentage (FMAP) formula. In Texas, the FMAP for federal fiscal year (FFY) 2012 is 58.22 percent, down by 2.3 percentage points compared to FFY 2011. This means that in FFY 2012 the federal government covers 58.22 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 MCOs to provide, arrange for, and coordinate preventative, primary, and acute care covered services, including pharmacy. STAR administers services to different eligible populations in different locations.

In the metropolitan service areas of Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, and Travis, STAR provides services for pregnant women, newborns, children with limited income and TANF recipients. Effective March 1, 2012, STAR expanded to the Medicaid Rural Service Area (Medicaid RSA). STAR in the Medicaid RSA provides services to the following populations:

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

SSI children age birth through 20 years of age may volunteer to participate in STAR in the Medicaid RSA.

STAR Health

HHSC worked with 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 state conservatorship and continuing to serve them in two transition categories:

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

HHSC administers the program under contract with a single 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 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 age 65 and older and have a disability. STAR+PLUS operates in the Bexar, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, 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 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

The 2012-13 GAA, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission), assumes a cost savings to the state budget resulting from the expansion of Medicaid managed care statewide. Effective September 1, 2011, PCCM Medicaid clients in 28 of the counties contiguous to existing STAR and STAR+PLUS service areas were transitioned from PCCM to the STAR program or STAR+PLUS Medicaid managed care program.

On March 1, 2012, HHSC implemented the following changes to the delivery of Medicaid/CHIP services:

- Expanded STAR and STAR+PLUS to South Texas,
- Expanded STAR+PLUS to El Paso and Lubbock service areas,
- Converted PCCM areas to the STAR program model,
- Included in-patient hospital services in STAR+PLUS,
- Included pharmacy benefits in managed care, and
- Expanded the dental managed care model for children in Medicaid.

Dental Managed Care

Through the following efforts and policies, HHSC facilitates the provision of dental services focused on quality outcomes for children in the Medicaid and CHIP programs:

- Quality, comprehensive dental services through qualified and accessible Texas dental providers;
- Improvement of oral health through preventive care and health education initiatives and activities;
- Intervention strategies to avoid disparities in the delivery of dental services to diverse populations, and providing dental services in culturally competent manner; and
- A choice of dental plans.

Effective March 1, 2012, children's Medicaid and CHIP dental services are provided through a managed-care capitated model. Each client will have a main dental home provider for an ongoing relationship with the client, including all aspects of oral health care delivered in a comprehensive, coordinated, and family-centered way. Main dental home providers will assess the dental needs of clients and coordinate clients' care with specialty care providers.

Services for Certain Clients

Texas Medicaid Wellness Program

The Texas Medicaid Wellness Program is a community-based, holistic care-management program that enrolls high-risk traditional 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 conversations that aim to improve health outcomes. The client's care team is led by a registered nurse that can include 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 on disease management and nutrition. Wellness clients receive between one and four

telephone and/or face-to-face visits per quarter, receive educational mailings quarterly, and also have access to a 24-hour nurse advice line.

The Diabetes Self-Management Training Program

The Diabetes Self-Management Training (DSMT) Program is a subprogram of the Texas Medicaid Wellness Program, and provides diabetics who elect to participate up to ten hours of targeted diabetes self-management training and three hours of nutritional counseling in the first year of enrollment. After completing the first year of DSMT enrollment, the clients may receive an additional two hours of DSMT education and an additional two hours of nutritional counseling per year. While enrolled in this subprogram, diabetics will continue to receive the array of services offered under the Texas Medicaid Wellness Program for their co-morbid condition. The DSMT program first served clients in April 2011 and ended in February 2012, as these clients transitioned to managed care, in which comparable services will be provided.

Managed Care for Children with Disabilities

Per legislative direction given in HHSC's Rider 59 in the 2010-11 GAA, HHSC began developing a managed care program for children with disabilities to improve the coordination of acute care for existing Medicaid recipients. As mentioned above, on March 1, 2012, adult wellness program clients transitioned to managed care. Children with disabilities are not a part of the mandatory transition at this time, and 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 (approximately by September of 2013), decisions about future care coordination for children with disabilities will be made.

Medicaid for Breast and Cervical Cancer

HHSC's Medicaid for Breast and Cervical Cancer (MBCC) programs provides 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 (CDC) National Breast and Cervical Cancer Early Detection Program. When a woman receives a qualifying diagnosis, from any provider, and her income is at or below 200 percent of the FPL, she becomes eligible. To apply for the MBCC 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.

The Medicaid Buy-In and Medicaid Buy-In for Children 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 countable earned income 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 available as are 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) with disabilities and family income up to 300 percent of FPL. Children in the Medicaid Buy-In program are eligible for the same Medicaid services available to children Medicaid clients. 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.

Federal law requires that employer-sponsored health insurance be used 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. Medicaid may cover certain services not paid for by an employer.

Medical Transportation

The Medical Transportation Program arranges nonemergency medical transportation for specific populations who do not have access to and from health care or dental providers:

- Eligible Medicaid clients;
- Children with Special Health Care Needs (CSHCN) program; and
- Qualifying clients in the Transportation for Indigent Cancer Patients program, for low-income individuals who
 - Are not enrolled in Medicaid or CSHCN,
 - Are diagnosed with cancer or cancer-related illness,
 - Meet program financial requirements, and
 - Reside in specific counties.

Transportation services include tickets for use on fixed- and demand-route public transportation bus services; demand-response transportation service provided by vendors using buses, vans or sedans; and mileage reimbursement to an individual enrolled in the Individual Transportation Provider program. Eligible clients age 20 and younger and their attendants can also access the following services: financial services through advancing funds when the responsible parent does not have the resources to transport the client to a health care appointment; and meals and lodging when the eligible requires an overnight stay away from their home due to medical reasons.

In FY 2011, the Medical Transportation Program served approximately 350,000 clients. The Program also received approximately 3.25 million telephone calls, which resulted in more than 9 million units of service provided that included one way trips, meals, and lodging.

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

Target Population

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

Service Description

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

Enrollment in the CHIP program increased significantly during the last two years, from approximately 500,000 in March 2010 to nearly 571,000 in March 2012. This represents a program growth rate of 14 percent over that period. The program is likely to continue growing during the rest of the 2012-13 biennium, with the average monthly CHIP enrollment for the program predicted to reach 588,000 during FY 2013.

As of March 2012, less than one percent of the 571,000 children enrolled in CHIP were under the age of 1; children ages 1-5 represented 17 percent; and children ages 6-18 represented almost 83 percent.

Compared to Medicaid, the higher proportion of CHIP clients in the older age groups is due in part to the different income eligibility requirements for CHIP and Medicaid.

Medicaid allows families with younger children to have higher income limits, and allowable family income for Medicaid decreases as children age.

CHIP Reauthorization

The CHIP Reauthorization Act of 2009 (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 2011, the federal CHIP allotment for Texas was \$832.7 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 health maintenance organizations (HMOs) 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.

CHIPRA also required Texas to provide expanded dental services to CHIP clients.

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 period a year. 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.

Coverage of Qualified Immigrants

Texas formerly provided CHIP coverage using general revenue for children who are in the country legally but ineligible for Medicaid coverage due to their immigration status. CHIPRA gave states the option of providing Medicaid or CHIP benefits to

qualified immigrant children and pregnant women, in accordance with previously enacted state law. 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

Previously, Texas could not claim federal matching funds for the dependents of public employees. Texas paid for CHIP coverage of eligible dependents of Teacher Retirement System (TRS) ActiveCare members with 100 percent general revenue funding. The Employees Retirement System (ERS) also provided a 100 percent general revenue premium subsidy toward eligible dependent coverage under the State Kids Insurance Program (SKIP).

The Affordable Care Act allowed the children of public employees to receive federally-matched coverage in CHIP. Texas began providing federally-matched CHIP coverage to qualifying TRS school-employee children on September 1, 2010, and to former SKIP clients on September 1, 2011. The receipt of federal match for CHIP coverage for TRS school-employee children is projected to increase the federal share of CHIP funding by \$42.4 million during the 2012-13 state fiscal biennium. The receipt of federal match for CHIP coverage for public employee children formerly eligible for SKIP is projected to save the state a total of \$14.7 million in general revenue funds in fiscal 2012.

5.4.4 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 \$263 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 2011, 46,349 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 45,000 on a monthly average basis during that period. More recently, due to improved economic conditions, the number of participating families has declined. By February 2012 the number of participating families had dropped by 8 percent, to 42,541 families, compared to August 2011. It is likely that some families who are eligible for the program are not participating.

Service 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

SNAP serves people with food insecurity, a concern for many low-income Texans. The U.S. Department of Agriculture (USDA) defines food insecurity as inadequate access to food to meet basic needs. The USDA found that during 2008-10, Texas had the second highest rate of food insecurity, at 18.8 percent, as compared to the national average of 14.6 percent.¹

The number of SNAP households in Texas has increased over recent years, partly as a result of the downturn in the economy. In February 2012, Texas issued a total of \$428 million in food benefits to nearly 3.6 million recipients, compared to \$221.4 million issued to 2.3 million recipients in March 2008. The amount in benefits issued has increased 93.3 percent, while the rise in recipients has increased by 56.5 percent.

¹ United States Department of Agriculture, Economic Research Service, "Statistical Supplement to Household Food Security in the United States in 2010," Administrative Publication No. (AP-057) 33 pp, September 2011.

In January 2000, Texas began outreach efforts for the Simplified Nutrition Assistance Program Combined Application Program for older SSI recipients. The program began in October 2001, adding approximately 60,000 eligible people to the SNAP program. In January 2012, there were 122,072 cases in this program.

Service 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.

Service Description

The 2-1-1 TIRN is a service for the public to communicate accurate, well-organized, and easy-to-find information from more than 60,000 state and local health and human services programs via phone or by Internet. Anyone may dial 2-1-1, 24 hours per day, 7 days per week, to receive referrals to health and human services on the local, regional, state, and national levels.

TIRN has established a service level agreement that 80 percent of calls will be answered in 60 seconds or less. In 2011, 2-1-1 TIRN handled more than 3.4 million calls for comprehensive information and referral, with an average of about 285,000 calls per month, up from 2.4 million calls in 2009. The website received about 3.2 million visits, up from about 700,000 in 2009.

Office of Immigration and Refugee Affairs

Target Population

Texas remains among the top states in number of refugee arrivals. The state received 7,235 refugee arrivals in FY 2011, 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 U.S. Department of Health and Human Services - Office of Refugee Resettlement (ORR) are eligible from the date on the certification letter.

Service 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 2011 OIRA provided 15,408 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. Like RCA, RMA is restricted to refugees who have lived in the U.S. for eight months or less. RMA eligibility and benefits are provided by regional HHSC Centralized Benefits Services staff.
- **Refugee Social Services** consist of 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 US citizenship. Currently, these grants target services for older refugees, single refugee parents, Cuban arrivals, and refugees of school age.
- **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 DFPS to provide services.
- **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 DSHS to provide services.

Disaster Assistance

Target Population

The Texas Disaster Act of 1975, in conjunction with the federal Disaster Relief Act, authorizes financial grants to individuals and households with disaster-related necessary expenses and serious needs, such as transportation, personal property, and medical, dental, and funeral expenses, in counties where the U.S. President has

declared major disasters. The program is available to all people who qualify regardless of race, sex, religion, color, or national origin. U.S. citizens, non-citizen nationals, or qualified aliens in the U.S. may apply, 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 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 (called FEMA) and HHSC. HHSC disaster assistance also includes identifying, obtaining, and delivering available food, water, and ice to shelters and bulk distribution centers. HHSC responds to emergencies and disasters, such as Hurricane Ike and the Bastrop wildfires of 2011, with necessary access to eligibility services for SNAP, Medicaid, and TANF benefits.

During the past 36 years, Texas has had 56 presidentially declared major disasters, such as floods, hurricanes, tornados, severe storms, and fires. Since 1974, expenditures have totaled approximately \$765 million in assistance provided to households impacted by disasters. Fifteen major disasters have been declared in Texas since 2001, and the program has aided more than 237,679 households and provided \$558 million dollars in assistance.

Family Violence Program

Target Population

The Family Violence Program (FVP) serves victims of violence who have been physically, emotionally, and/or sexually abused by a family or household member. In 2010, the Texas Department of Public Safety, together with the Texas Council on Family Violence, reported that 142 women were killed by their intimate partner. Additionally, 193,505 incidents of family violence were reported in the state.

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.

Service 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, educate the public, and provide training and prevention support to various agencies.

FVP contracts with non-profits 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 contracts with six shelter centers in 1979 to 69 shelters, ten non-residential centers, and 16 special non-residential projects in FY 2012.

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.

Service Description

These programs help clients apply for SNAP, TANF, CHIP, and Children's Medicaid. Texas is also experiencing an increase in obesity and diabetes. Nutrition education helps combat these problems with focused education taught specifically to the low-income population served by SNAP. As program capacity increases, administrative work increases due to monitoring requirements and technical support to a larger number of contractors.

Alternatives to Abortion

Target Population

Alternatives to Abortion serves pregnant women by offering options to support and encourage childbirth. Services are provided at 46 sites across the state. More than 26,000 women received services in FY 2011.

Service 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 free to clients. Clients can continue to receive these services until the child is one year of age. Currently the Alternatives to Abortion program has 34 providers with 46 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 as well as 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.

Service 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 under Healthy Marriage for FY 2012 include the:

- Twogether in Texas Service Network and Web Portal, and
- Technical Assistance for participants and providers.

In FY 2012, there are 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.

5.4.5 HHSC Goal 7: Office of Inspector General

Target Population

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

- HHS employees,
- MCOs,
- Contractors and subcontractors,
- Providers and their staffs, and
- Recipients and beneficiaries.

Service 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 investigation of waste, abuse, and fraud in the provision of HHS programs. OIG fulfills its responsibility through a variety of activities.

- Issuing sanctions and performing corrective actions against program providers and recipients, as appropriate.
- 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.
- Conducting investigations and reviews and monitoring cases internally, with appropriate referral to outside agencies for further action.
- 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.
- Investigating criminal allegations of abuse, neglect, and exploitation at SSLCs and SMHs.

Advancing the HHS mission and Governor Rick Perry's Executive Order RP-36, dated July 12, 2004, OIG initiates proactive measures and deploys advanced information technology systems to reduce, pursue, and recover expenditures that are not medically necessary or justified. These measures and automated systems enhance the ability of OIG to identify inappropriate patterns of behavior and allow

investigative resources to target cases with the strongest supporting evidence and greatest potential for monetary recovery.

OIG routinely takes proactive measures to reduce errors in the billing, payment, and adjudication of claims for Medicaid services. These measures include training for Medicaid providers, HMOs, staff of the claims administrator, and provider organizations. OIG staff actively participates in the rendering of medical and program policy recommendations to reduce erroneous payments while maintaining or improving quality of care for the Medicaid recipient. These proactive efforts have allowed OIG and HHSC to increase cost-avoidance activities and sustain improved relationships with Medicaid providers.

In February 2011, CMS promulgated rule 42 CFR §455.23, which requires that the state Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of Medicaid fraud unless the agency has good cause to not suspend payments or to suspend payment only in part. OIG implemented policies and procedures to comply with the rule, placing its first payment suspensions in June and July of 2011.

Effective April 1, 2012, OIG's investigative authority extends to SMHHs. This expansion of responsibility is reflected in a revision to the current MOU among OIG, DADS, DSHS, DFPS, and the Office of Independent Ombudsman for SSLCs. The MOU now provides that all criminal allegations of abuse, neglect, and exploitation at these facilities will be referred to OIG for investigation. OIG anticipates that this expanded scope of responsibility will result in more than 600 additional cases for investigation each year. As a result, OIG is establishing a separate investigative unit that will be specifically tasked with investigating criminal allegations at all SMHHs.

Initiative: Office of Inspector General Public Awareness Campaign

OIG will create and implement a public awareness campaign to increase use of OIG's services. The campaign will be preceded by several initiatives.

- Improving OIG's interfaces with the public, which includes streamlining the operation of the toll-free hotline and a re-design and upgrade of OIG's public web presence.
- Improving OIG's communications protocols with HHS program areas, which will enhance coordination of program integrity and fraud prevention efforts.
- Assisting in the implementation of appropriate policy changes that require providers to perform certain compliance activities as a condition of participation.

Once these initiatives have been completed, OIG will then launch a campaign, with HHSC's assistance, that specifically includes aggressively publicizing the toll-free hotline, OIG's web presence, and provider training on the compliance activities that are conditions of program participation, such as the required self-reporting of

overpayments, educating staff on whistleblower protections, and how to report instances of fraud and abuse.

5.5 Internal Assessment

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.

5.5.1 Continuous Improvement of Business Processes

The HHS 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

Meeting increased demand for eligibility determination through innovation and technology requires a modernized workload management system. Currently, the majority of applications are on paper which slows down processing and increases the possibility that applications can be lost or misplaced. Paper applications cannot be shared outside the office, meaning an office across town or across the state cannot help out an office that is overloaded. Current business processes are location-specific, based on zip code, and they encourage face-to-face interactions in local offices. Some offices have too much work while others are under-utilized. Other business processes are time intensive and create inefficiencies.

The newer TIERS system allows work to be shared statewide. Use of the eligibility website, www.yourtexasbenefits.com, replaces paper applications with electronic ones, which also enables work to be shared during disasters. Website usage in general reduces local office visits.

Medicaid Information Technology Architecture

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

Streamlining Contract Management

HHSC participates in the HHS System Contract Council, described in *Section 4.5.3, Health and Human Services System Contract Council*. The council works to improve contract management across the HHS System, streamlining and standardizing where appropriate. HHSC's Administrative Services Development and Contract Oversight and Support Director participate in accomplishing the tasks identified in the council's Improvement Plan, communicating with and seeking input from agency stakeholders as appropriate.

In addition to the council's initiatives described in *Section 4.5.3*, the council's Improvement Plan contains the following items for consideration:

- Defining and implementing Legislative Budget Board's On-Line Contract Reporting Requirements for all HHS agencies to report monthly and annually on all contracts that reach a certain threshold as defined by statute, and
- Establishing a governance structure for all HHS agencies to develop a model program for supporting Historically Underutilized Businesses.

Specific HHSC involvement will include a variety of activities.

- HHSC will conduct an internal assessment of contract procurement, enrollment, and renewal processes to identify areas for improvement and standardization.
- Once an interagency contract template is developed and approved by the council, HHSC will coordinate with internal agency stakeholders to obtain final approval and coordinate policy development as appropriate.
- Once the Enterprise Electronic Signature policy is finalized, HHSC will work with internal agency stakeholders to develop internal policy and procedures for implementation.
- HHSC will facilitate the development and/or revision of policies and procedures and forms, which will be published in HHSC Contracting Processes and Procedures Manual as applicable and necessary.

5.5.2 Maintaining and Developing the Workforce

Statewide Training / Positive Performance

In response to a State Auditor's Office (SAO) report, the Training and Organizational Development Unit was created to standardize system-wide training and evaluation. To effectively address the audit recommendations, the unit has implemented several programs which include the following:

- Developing and delivering training programs to help supervisors and managers in acquiring the knowledge and skills to better manage job requirements;
- Developing and ensuring ongoing implementation of the curriculum for the instructor-led Training Program for Managers;

- Creating a system to track, update, and report on the HHS required training compliance for each agency;
- Implementing a leadership development program; and
- Assisting HHS organizational leaders and their groups improve productivity and employee satisfaction. This is accomplished through organizational development trainings and presentations tailored to address specific areas of concern.

The unit expanded use of current technology, such as distance learning, to facilitate greater access to training and reduce travel and other costs. Another initiative is a train-the-trainer approach to provide a network of qualified trainers to teach the management development and required courses to staff throughout the state. Additional technology improvements include design and implementation of the Enterprise Learning Management System, which is part of the ProjectONE initiative, an enterprise resource planning system discussed below.

Several future activities are planned.

- Implementing additional supervisor/management training which was recommended in the SAO audit and implementing instructor-led workplace safety training to provide employees with tools and techniques to protect themselves on the job
- Offering professional development opportunities, such as lunch-and-learn and workshops, through variety of media, and increasing self-service functionality through better use of simulations tools
- Migrating existing courses to a centralized system to improve training notifications, reporting, and other functionality
- Conducting gap analyses to identify trends that indicate the effectiveness of training offerings, and developing additional trainings

Survey of Employee Engagement

Using data from the 2012 Survey of Employee Engagement, HHSC will create viable and lasting solutions to areas of concern and strengthen the function of the organization. The survey data will be utilized as a management tool to monitor and evaluate how the agency is doing and how staff feel about their employment.

The proposed plan is to work with each division director and his/her key leadership. In these sessions, decisions regarding areas for improvement will be made based upon a detailed analysis of data. To address consistently low scores, a project team will conduct focus groups to gain a broad consensus on ways to address the identified issues. Using project management methodology, the agency will be able to document follow-up actions and better report results to employees. More information about the survey is included in Appendix F.

Retirements and Succession Planning

Over the next five years many baby boomers will retire, and the HHS System will lose many senior-level employees with significant institutional knowledge. By creating a succession plan, HHS agencies can ensure it will have a workforce of qualified and skilled managers and other workers to provide quality services to Texans.

The current practice of rehiring retirees may inhibit talented staff from moving into management or other senior positions. To address this problem, HHS has adopted a requirement that, before offering a supervisory position to a retiree, the hiring authority must document that: the retiree is the only candidate qualified to occupy the position or is the best qualified candidate for the position, and that efficiency, quality, or effectiveness will improve if the retiree is selected, or that it will deteriorate unless the retiree is selected. This requirement ensures that the hiring authority carefully considers and documents the selection of a retiree.

HHS Executive Leadership Academy

To promote the development of staff, HHS 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 a HHS Executive Leadership Academy, a formalized interagency succession planning and mentoring program. The Academy provides training 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 Academy 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 management skills and the careful selection of qualified staff, HHS will continue to meet the challenges posed by increased retirements.

5.5.3 Addressing Infrastructure Needs

Physical Security of State Offices

The safety and security of health and human service staff and customers is always a priority. HHS Business and Regional Services (BRS) will continue to conduct vulnerability assessments of HHS facilities and local practices and recommend mitigations. With guidance from BRS, HHS offices will be required to develop office

emergency action plans to pre-identify risks and roles and responsibilities in the event of an incident.

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.

ProjectONE

In response to H.B. 3106, 80th Legislature, Regular Session, 2007, the Comptroller of Public Accounts established an enterprise resource planning system to create a common database and common software tools. This system, known as ProjectONE, is designed to allow real-time information to be accessed, shared, and compared easily and immediately across agencies and organizations.

As an initial step of this project, HHS is upgrading the current system to act as the foundation for the statewide system. This system will be known as CAPPS (Centralized Accounting and Payroll/Personnel System). Currently, HHS staff is assisting in the testing of the system to ensure that it provides employees and managers an efficient process to complete administrative tasks. HHS staff will provide training for managers during the strategic planning timeframe of 2013-17.

Office Space Reductions

Evolving technology, service delivery practices, and staffing models provide an opportunity to decrease the brick and mortar footprint of HHS 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.

Information Technology

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. 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. While this may result in a reduction in space and maintenance requirements, expanded technology capacity and security enhancements will be needed to support remote access to the agency's systems and data.

HHSC IT will also assist with meeting the agency's and customers' needs by providing additional ways for clients to access services and information. HHSC has

several modernization efforts underway where HHSC IT's involvement is critical 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 modernization efforts include updating eligibility and Medicaid systems and processes, modifying systems to be more modular and interoperable with other systems, implementing data warehouse functionality for improved reporting and policy making, and using new technologies such as cloud services.

This dual focus—providing additional functionality and access mechanisms while ensuring security and legal compliance—requires complex coordination and analysis across a broad variety of stakeholders. HHSC IT will strive to meet both these objectives as it implements improvements in business processes and service delivery.

5.5.4 Improving Data Quality and Use

Obtaining Managed Care Data to Ensure Quality

Obtaining reliable data on managed care providers and services is an area that has been targeted for improvement. 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. 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 Initiatives

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

The goal of HIT is to allow comprehensive management of medical information and its secure exchange between health care consumers, providers, and payers to improve the quality of care, prevent medical errors, reduce health care costs, and increase administrative efficiencies. HIT initiatives include, but are not limited to,

Electronic Health Records (EHRs), electronic prescribing, and health information exchange (HIE) systems.

The Texas Legislature directed HHSC to develop a Medicaid-based HIE system to support improved quality of care by giving providers more and better information about their patients. With a new and increasing focus on support of and coordination among HIT initiatives, both internal and external to the HHS System, it will be important for HHSC to develop and maintain an active and explicit focus on HIT promotion and coordination in the coming years.

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

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

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

Health Information Exchange Plan

To ensure the coordination of 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 a 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 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 has begun a pilot program that will enable Medicaid/CHIP to use clinical data collected by regional HIEs.

HHSC launched the Medicaid EHR Incentive Program in March 2011 and began disbursing incentive payments to eligible professionals and hospitals in May 2011.

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. New functions became available to pharmacies and providers in December 2011.

- The Medicaid/CHIP drug formulary 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 also 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 speeding access to prescription drugs.
- Medication histories of Medicaid/CHIP clients are available for providers and pharmacies, integrated alongside formulary and benefit eligibility information.

Additionally, HHSC continues to implement the Medicaid Identification Card and Health Information System project, which will provide a web-based portal for providers to utilize a fully-functional e-prescribing solution. Medicaid/CHIP clients will be able to benefit from e-prescribing functionality even when their provider does not have their own system. Subsequent releases are planned to be completed during 2012 that will add more effective functionality associated with electronic health history, e-prescribing, and on-line explanation of benefits verification.

Enterprise Data Warehouse

In accordance with HHSC's Rider 43 in the 2012-13 GAA, HHSC is developing an Enterprise Data Warehouse and Business Intelligence (EDW/BI) solution for strategic decision-making and achieving operational improvements to Texas Medicaid programs and functions within the HHS system. The integration of data across all HHS agencies will be used to:

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

The EDW/BI solution will align and complement the goals and objectives of other HHS initiatives, including MITA, conversion to the ICD-10 medical classification list, HIEs, enterprise data governance, and Medicaid Management Information System Replacement projects. In the context of HHS, EDW functionality will establish a unified and contextually accurate view of a client and a provider, and it will

incorporate data governance to ensure the information is reliable and secure. The EDW/BI solution will provide enhanced access to usable, consistent information to solve problems and to reveal trends to promote improved Medicaid services.

HHSC's vision for an EDW/BI solution includes:

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

The EDW/BI is nearing culmination of its planning phase, having completed a needs assessment, cost/benefits analysis, solution alternatives analysis, and a draft request for proposal outlining a roadmap and detailed requirements for design, development, and implementation services. It is anticipated the vendor solicitation phase will commence in September 2012, once CMS funding approval has been received.

The primary focus during the first 24 months of the EDW/BI implementation will be the delivery of a strong Medicaid-focused data management that provides a single, accurate, and authoritative view of Medicaid data and the creation of a foundation for core EDW/BI functionality. This EDW/BI core functionality will support Medicaid-related reporting and analysis required to address critical needs for improved data and advanced analytics. Subsequent EDW/BI implementation efforts will focus on the migration of existing business intelligence and data mart environments and enabling strategic health care reform mandates, such as ICD-10 compliance and HIEs.

Chapter 6

Department of Aging and Disability Services External/Internal Assessment

6.1 Overview

The Department of Aging and Disability Services (DADS) provides a continuum of long-term services and supports that are available to older individuals and individuals with disabilities. In addition, the regulatory component of DADS licenses and certifies providers of these services and monitors compliance with regulatory requirements. Senate Bill (S.B.) 6, 79th Legislature, Regular Session, 2005, transferred the Guardianship Services Program from the Department of Family and Protective Services (DFPS) to DADS, effective September 1, 2005.

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 Assessment,
- Current Activities, and
- Internal Assessment.

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 Assessment

6.3.1 Refocusing Service System to Meet Increased Demand and Changing Profile of Individuals Needing Services

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

- Promote the delivery of locally-driven health care that integrates both 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 function independently.

Discussion

The demand for long-term services and supports in Texas continues to grow, and 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 age 65 and older is projected to increase from 2.8 million in 2013 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 3.2 million in 2013 to 6.7 million in 2040. The population of people with disabilities under age 65 is projected to increase from 2 million in 2013 to 3.4 million in 2040. The population of people with disabilities age 65 and older is projected to increase from 1.2 million in 2013 to 3.3 million in 2040.

Looking only at the next ten years, the number of Texans ages 65-74 is estimated to increase by about 60 percent. If this population uses Medicaid long-term services and supports at the same rate as the current generation of people 65-74, DADS can expect increases on the order of 60 percent—for instance, more than 5,000 more people using Medicaid nursing facility (NF) services and more than 20,000 more using home and community-based services in this age group alone.¹

¹ Note that these are only estimates of future utilization and that actual utilization could vary. For instance, the aging baby boom population may turn out to be healthier and need fewer services than the previous generation in that age group.

DADS serves more than 4,200 older individuals (age 60 and over) with intellectual and developmental disabilities (IDD) in State Supported Living Centers (SSLCs), community intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and waiver programs. Their numbers have increased substantially over the past ten years. Over the next ten years, the number of individuals aging with IDD who receive waiver or institutional services can be expected to increase by an estimated 40 percent, to about 5,900 (excluding any new waiver enrollees during that time).

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 boom and often has multiple children, the baby boomers themselves have fewer children, are more often childless, and are less likely to be currently married. Any of these factors could reduce the numbers of those who may be available to provide informal supports.

Co-Occurring Behavioral Health Needs

The incidence of behavioral health issues is increasing for persons with a physical or intellectual/developmental disability and in the aging population. Nearly two-thirds of the overall SSLC population has a dual diagnosis in which an individual has been diagnosed with an intellectual disability and a mental health disorder, as do almost 90 percent of those individuals who were admitted to the SSLCs in the past two years. Nearly one-fourth of individuals across all DADS waiver programs has a dual diagnosis. The percentage of individuals in certain waivers is even higher, such as in the Home and Community-Based Services (HCS) waiver, where 36 percent have a dual diagnosis.

The additional challenge of a behavioral health diagnosis can further limit these individuals' 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 end up in institutional services, and the easier it will be for such individuals to 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 93,959 in fiscal year (FY) 2007 to 147,252 in FY 2011, a 57 percent increase. The interest list for the Community Living Assistance and Support Services (CLASS) program alone grew 123 percent during this time. This growth occurred despite significant increases in waiver funding in the 2007 and 2009 legislative sessions, reflecting the public's increasing awareness of and desire for community-based long-term services and supports.

Planned Actions

Federal Funding Options

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

- The **Balancing Incentives Program** provides an increase in federal match in return for the establishment of a “single point of entry/no wrong door” system for accessing long-term services and supports in local communities.
- The **Community First Choice Program** 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.

Senate Bill 7

S.B. 7, 82nd Texas Legislature, First Called Session, 2011, directs HHSC to pursue a federal Medicaid waiver to, among other things, “allow for the redesign of long-term care services and supports to increase access to patient-centered care in the most cost-effective manner.” The bill also established the legislative S.B. 7 Medicaid Reform Waiver Legislative Oversight Committee. DADS and HHSC will work with the committee to explore options for this waiver, including the possible redesign of the state’s current 1915(c) waivers, as well as the funding options listed above, to provide greater flexibility and cost-effectiveness for the state’s Medicaid services.

Addressing Behavioral Health Needs

DADS will work to address the need to better serve individuals with behavioral health conditions in its programs. DADS will explore funding options, including the Legislative Appropriations Request process and the Money Follows the Person (MFP) demonstration program, to:

- Pilot the use of behavioral intervention teams, which are mobile interdisciplinary teams of mental health professionals able to intervene early in crisis situations to provide assessment, evaluation, and training to avoid unnecessary hospitalization or institutionalization;
- Provide training for families, direct services staff, and clinical professionals in the use of positive behavior supports/management to prevent crisis situations from developing;
- Expand the existing Bexar County MFP behavioral health pilot for individuals moving from NFs to the community to include additional communities and program populations; and

- Add behavioral health services to the service array in those waiver programs where they are currently lacking.

Refinancing General Revenue Funds to Texas Home Living Waiver

To maximize the use of state funds, the 82nd Legislature, DADS Rider 45, General Appropriations Act, 82nd Legislature, Regular Session, 2011, directed DADS to refinance general revenue-funded services to create 5,000 Texas Home Living (TxHmL) waiver slots. This enables the state to receive a federal match for its general revenue funds, thus expanding the number of individuals who can be served. The TxHmL waiver provides selected services and supports for people with IDD who live in their family homes or their own homes. Services include adaptive aids, minor home modifications, specialized therapies, behavioral support, dental treatment, nursing, community support (similar to supported home living in HCS), respite, day habilitation, and employment services.

Expanding Utilization Review

An important part of responding to high demand for services is making sure that services are provided in the most cost-effective manner possible. The General Appropriations Act (GAA) directs the agency to “employ utilization management and utilization review practices as necessary to ensure that the appropriate scope and level of services are provided for individuals receiving services in Medicaid 1915(c) waivers.” (Health and Human Services Agencies, Special Provisions, Section 56(c) in the 2012-13 GAA) Utilization review is a process where nurses or qualified intellectual disability professionals review individual service plans and levels of care to determine an appropriate level and scope of services. DADS will continue to expand utilization review activities to ensure that services provided are appropriate to meet the individual’s needs and to identify any unmet needs of the individual.

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

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

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

Discussion

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

The 82nd Legislature enacted several pieces of legislation that affect the SSLCs. S.B. 41, 82nd Legislature, Regular Session, 2011, relates to the use of restraints in SSLCs. The bill requires that restraint be used only in very limited circumstances, that rules be developed related to restraint usage, and that reporting of restraint usage be supplied to the Executive Commissioner.

In addition, House Bill (H.B.) 3197 requires the SSLC Division to establish a pilot project related to culture change at an SSLC. Brenham SSLC was chosen for this project.

The 81st Legislature enacted a comprehensive package of legislation, appropriations, and budget riders in response to growing concerns about the quality of care provided through SSLCs and other services for individuals with IDD. This legislation included S.B. 643, 81st Legislature, Regular Session, 2009, and the 2010-11 General Appropriations Act (Article II, Special Provisions, Section 48, S.B. 1, 81st Legislature, Regular Session, 2009). The efforts related to operationalizing and maintaining these initiatives are ongoing.

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.

Planned Actions

As part of the implementation of S.B. 41, a revised restraints rule has been developed and an operational policy developed to guide its consistent implementation. Work on the rule and policy revision began in June 2011 and is slated for full implementation, including staff training, in the summer of 2012. As part of the implementation of H.B. 3197, the Brenham SSLC was selected to host the culture change project and is currently working on implementation. A final report regarding this pilot project will be produced in FY 2013. Article ii, Department of Aging and Disability Services, H.B. 1, 82nd Legislature, Regular Session, 2011, tasked DADS with identifying gaps in processes and policies related to reporting of licensed professionals who have committed confirmed acts of abuse, neglect or exploitation. Work began on this project in January 2011, and the a final report was submitted to the Legislature on May 23, 2012.

The key initiatives of S.B. 643, 81st Legislature, Regular Session, 2009, which are ongoing efforts of the SSLCs and other sections of the DADS organization, include:

- Employee and volunteer fingerprint-based criminal background checks and random drug testing;
- Improved training at SSLCs and in community programs;
- Installation of video surveillance cameras in common areas of all SSLCs;
- Creation of the Office of Independent Ombudsman for SSLCs, to report to the Governor's office;

- Development of a forensic center for high-risk alleged offenders at the Mexia SSLC; and
- Creation of a comprehensive investigations database to include data related to allegations/confirmations of abuse, neglect and exploitation for all IDD providers.

Projects addressing these provisions began in June 2009 and were implemented by September 2011. These will be ongoing activities for the SSLC division and other relevant areas of the DADS agency during the 2013-17 planning period.

Efforts are also underway to reduce the number of residents at SSLCs by developing census management plans for each SSLC, while respecting individual choice and promoting improved quality of care, better staffing, and effective management at each center. The Community Living Options Information Process is being used to ensure that appropriate information is shared with individuals and their families or legally authorized representatives regarding available community placement alternatives, and to help identify individuals who may be interested in moving to the community. With these efforts, the census in SSLCs was 3,844 in May 2012, a 22 percent decrease from August 2006, with an average of a 4 percent census reduction per year.

The DOJ settlement agreement, signed in June 2009, includes 20 detailed sections related to improvements in quality of care, protections from harm, health and professional services, and serving persons in the most integrated setting. As provided under the agreement, three monitoring teams conducted baseline reviews of each center and identified areas where service delivery improvements are required. They also conduct compliance reviews every six months to measure compliance with the elements of the settlement agreement.

6.3.3 Paying for Quality of Long-Term Services and Supports

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

- Work with partners to develop public health strategies to improve outcomes and to contain health care costs.

Discussion

The rate of hospitalization of NF residents is a significant indicator of NF quality of care. Failure of an NF to provide effective preventive services, early treatment of acute illness and management of chronic conditions can all contribute to a high hospitalization rate (and increased acute care costs). In a 2011 American Association of Retired Persons (AARP) study comparing states on quality of care

and other measures, Texas was ranked 42nd in the nation for NF hospital admissions.²

Some NFs in Texas and nationally are implementing culture change initiatives to improve quality of care, including improved health outcomes. “Culture change” in this context refers to service models based on person-directed values and practices, and designed to create an environment of dignity and respect for older adults by allowing them to participate in determining how their services are provided.

One example of culture change is the Green House³ program, a model for residential long-term care that involves a redesign of the philosophy of care, architecture, and organizational structure normally associated with long-term care. Green House homes, or facilities similar to the Green House model, are independent, self-contained homes for 6 to 12 people, designed to look like a private home in the surrounding community.

Current statute allows HHSC to establish an incentive payment program for NFs. The program must be designed to improve the quality of care and services provided to Medicaid recipients. No funding was appropriated for the program in the 2012-13 biennium.

Planned Actions

DADS is working with HHSC to explore the possibility of using revenues from a Medicare-Medicaid shared savings pilot to implement a quality incentive program for NFs aimed at reducing hospitalization rates. The state’s portion from a shared savings program could provide a reward for NFs that reduce residents’ Medicaid and Medicare acute care expenditures through the use of specified quality improvements.

A provider using a culture change model or other quality improvement effort to reduce hospitalizations could agree to provide those improvements on an at-risk basis. In this approach, the provider would receive an enhanced reimbursement rate in return for achieving specified acute care savings beyond any savings trend experienced by the NF population in general. Failure to achieve the savings goal would result in recoupment of the incentive payment.

Additionally, DADS has established a nursing facility culture change initiative to support NFs that provide individualized services that reinforce well-being, dignity and

² “Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers”, Susan C. Reinhard, Enid Kassner, Ari Houser, and Robert Mollica, September 2011, http://www.longtermscorecard.org/~media/Files/Scorecard%20site/Report/AARP_Reinhard_Realizing_Exp_LTSS_Scorecard_REPORT_WEB_v4.pdf.

³ Center for Healthcare Strategies, “Medicaid-funded Long-Term Supports and Services: Snapshots of Innovation”, Gretchen Engquist, PhD, Cindy Johnson, William Courland Johnson, PhD, page 11, May 2010, http://www.chcs.org/usr_doc/LTSS_Innovations.pdf.

choice for each person. A series of training webinars is planned for 2012 and beyond, offering continuing education credit for a variety of professionals. All educational materials will be posted to the DADS Culture Change webpage for nursing facility trainers to provide to their staff. DADS will also present a one-day symposium in several areas of the state, beginning in 2012, discussing culture change and person-directed services.

6.3.4 Improving Local Access to Long-Term Services and Supports

Strategic Priority: Encourage partnerships and community involvement.

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

Discussion

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

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 will continue expansion of the Aging and Disability Resource Centers (ADRCs) initiative, which began as a federal grant from the U.S. Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) in 2005. ADRCs serve as a “no wrong door” approach to services and are comprised of a network of local service agencies, coordinating information and access to public long-term services and supports 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 (AAAs). ADRCs may also include key partners from HHSC benefit offices, hospital discharge planners, mental health authorities, independent living centers, and other community organizations.

Planned Actions

Aging and Disability Resource Center Expansion

DADS "20/20 Vision" is to establish 20 ADRCs in Texas by the year 2020, aligning with AoA's requirements for statewide expansion in Texas. As of February 2012, DADS has established a total of 14 ADRCs operating in 10 of the 11 Health and Human Services (HHS) System regions and has relied upon federal grants, unexpended State Unit on Aging (SUA) administrative funding, and MFP funds to fund ADRC expansion efforts. Also, DADS is working with HHSC to explore federal funding opportunities through the Balancing Incentives Program to expand the ADRC model statewide as a "no wrong door" system.

Community Living Program

The DADS Community Living Program (CLP) has created a partnership with the Central Texas ADRC and Scott & White Healthcare to establish a nursing home diversion program for individuals at imminent risk for nursing home placement and Medicaid spend-down. A second CLP site was added in 2009 as a partnership between DADS, the AAA of Tarrant County, and the ADRC of Tarrant County. This CLP project site also targets caregivers and older persons at imminent risk of nursing home placement and Medicaid spend-down. Both project sites have a U.S. Department of Veterans Affairs (VA) component, wherein the ADRCs have a direct, fee-for-service arrangement with the local VA hospital system to provide care transitioning for veterans from the hospital to home.

6.3.5 Expanding Opportunities for Competitive, Integrated Employment for Persons with Disabilities

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

- Ensure policies and services that encourage responsibility and improve access to employment.

Discussion

In addition to improving quality of life for an individual with disabilities, employment is cost-effective for the individual, for service funders (e.g. DADS) and for taxpayers. With assistance from the State Employment Leadership Network—a collaborative between the National Association of State Directors of Developmental Disability Services and the Institute for Community Inclusion—DADS developed and is implementing an initiative to increase the employment participation of individuals receiving services from DADS programs.

Planned Actions

The goals of the initiative include:

- Developing consistent definitions and rates for employment assistance and supported employment across programs in waivers, rules, provider manuals, billing guidelines, and contracts;
- Revising other services to remove employment disincentives;
- Conducting outreach, delivering training, and making resources available through conference presentations, alerts, provider letters, the Employment Services webpage, a video of SSLC residents who are employed, and an Employment Services manual;
- Seeking input from providers and other stakeholders about employment topics through a subcommittee of the Promoting Independence Advisory Council and a LinkedIn group;
- Improving coordination with the Department of Assistive and Rehabilitative (DARS) and delivery of employment services to DADS consumers with IDD; and
- Improving collection and reporting of employment data.

DADS has also received funding through the MFP Demonstration Grant for a Customized Employment Project to provide individuals with disabilities more opportunities to move out of congregate segregated employment settings and into employment at local places of businesses. The project will be structured as a collaborative effort with DADS, Medicaid providers, individuals with disabilities who are receiving services from DADS, DARS, and other state agencies as key stakeholders.

6.3.6 Preparing for the Aging of the Texas Population

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 function independently.

Discussion

As the population of older people grows, DADS must continue to provide additional supports to state government, local communities, and individuals to address aging-related issues. The population of people 60 years and older was about 3.7 million in 2010, or about 14 percent of the population. Further, as discussed in Chapter 3 of this Strategic Plan, the population of people age 65 and older is projected to increase from 2.8 million in 2013 to 7.5 million in 2040. The percentage of the total

population that is 65 years of age or older is projected to increase from 10 percent in 2013 to 17 percent by 2040.

To address this demographic shift, DADS continues to develop and implement initiatives and programs focused on a number of issues, including meeting the need for building community capacity to serve the aging population, promoting wellness, and increasing access to informal caregiver support services.

Planned Actions

Aging Texas Well

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

The ATW initiative supports projects that promote wellness and healthy aging. These projects include:

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

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 Texercise program promotes individual activity, community events, and policies that support wellness in all life areas. The Texercise program provides an array of educational, motivational, and recognition resources 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. Texercise program activities will continue through 2013-17.

Texas Lifespan Respite Program

Informal caregivers—relatives and friends who provide unpaid care—are considered the backbone of the long-term services and supports system. Respite services provide temporary relief to caregivers from their duties and may be provided in home or institutional settings. For example, a respite program might offer in-home care for an aging individual to allow the person's spouse to go grocery shopping.

The Texas Lifespan Respite Program was established in 2009 with both federal and state appropriations. The program works closely with the Texas Respite Coordination Center and the advisory Texas Respite Coalition 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 models of service 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.

DADS will continue to support local community partners to identify local, state, and federal resources for sustainability.

6.4 Current Activities

6.4.1 DADS Goal 1: Long-Term Services and Supports

Target Populations and Service Descriptions

Community-Based Services⁴

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.

Medicaid community-based entitlement services include Community Attendant Services (CAS), Day Activity and Health Services (DAHS) and Primary Home Care (PHC). An entitlement program means that the state must provide those services to all individuals who request such services and are determined eligible.

In FY 2011, the average number of individuals per month receiving Medicaid community-based entitlement services by program was as follows:

- CAS—45,641,
- DAHS—17,924, and
- PHC—53,625.

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.

In addition, Medicaid Hospice is an entitlement program providing support to qualified individuals who have a physician prognosis of six months or less to live. In FY 2011, the average number of individuals per month receiving Medicaid Hospice services in a community setting was 707.⁵

While program eligibility criteria for waiver programs are similar to those for institutional programs, the federal government allows states to waive certain requirements (e.g., comparability, eligibility, and statewide availability) and limit the number of individuals served. Medicaid waiver programs are dependent on specific state and federal appropriations. Individuals are placed on a waiver interest list when the demand for services is greater than the number of available program slots.

The Medicaid waiver programs include:

- Community-Based Alternatives (CBA),
- CLASS,
- Deaf-Blind with Multiple Disabilities (DBMD),
- HCS,
- Medically Dependent Children Program (MDCP), and
- TxHmL.

The STAR+PLUS model serves older individuals and those who are blind or disabled, 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; and
- 2012—Expansion to 2 counties in the El Paso area, 15 counties in the Lubbock area, and 10 counties in the Hidalgo area.

In FY 2011, the average number of individuals per month receiving services through Medicaid waivers by program was:

- CBA—22,849,
- CLASS—4,623,
- DBMD—151,

⁵ In fiscal year 2011, the Medicaid Hospice Program served an average of 6730 individuals of whom 707 individuals received hospice services in the community and 6073 individuals received hospice services in nursing facilities (NFs).

- HCS—19,382,
- MDCP—2,437, and
- TxHmL—901.

Services funded through the Title XX Social Services Block Grant include Adult Foster Care (AFC), Client Managed Personal Attendant Services (CMPAS), DAHS, Emergency Response Services (ERS), Family Care (FC), Home Delivered Meals, Residential Care, and Special Services for Persons with Disabilities (SSPD). Services funded through general revenue include In-Home and Family Support Services.

In FY 2011, 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—59,
- CMPAS—430,
- DAHS—2,688,
- ERS—16,412,
- FC—6,044,
- Home Delivered Meals—16,146,
- Residential Care—496, and
- SSPD—93.

The Program for All-Inclusive Care for the Elderly (PACE) uses a comprehensive care approach providing an array of services for a capitated monthly fee. PACE provides all health-related services for an individual, including inpatient and outpatient medical care, and specialty services (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 2011, the average number of individuals per month receiving PACE services was 989.

In 2011, a number of changes were made to the PACE program, including changes to slot allocations. Passage of H.B. 2903, 82nd Legislature, Regular Session, 2011, expanded the program by providing individuals residing in NFs the ability to use the MFP initiative to access PACE, and provided individuals being offered STAR+PLUS services the option of accessing PACE, when the PACE site has available slots.

Ageing Services under Older Americans Act

The Department is designated as the SUA and as such is the single state agency responsible for administering programs and services under the federal OAA administered by the AoA. To ensure the mandates of the OAA are met, DADS

allocates funding and administers programs and services through performance contracts between DADS and a network of 28 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 for 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, and both formal and informal. Access and assistance services include information, referral and assistance, care coordination, benefits counseling, and 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 criteria 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 (physical or intellectual disabilities, language barriers, cultural, social, or geographical isolation).

Local Authority Services

Through 39 LAs, DADS offers state-funded community-based services for individuals with a diagnosis of an intellectual disability (ID) who meet diagnostic and functional need criteria. LAs serve as the point of entry for publicly funded programs for persons with IDs. The program may be provided by public or private entities. LAs provide or contract to provide an array of services for persons with IDs, and assist individuals interested in applying for enrollment into the following Medicaid supported programs: Intermediate Care Facilities for Persons with Intellectual Disability (ICFs/IID), SSLCs, HCS, and TxHmL.

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 funded through state funds, with the exception of some service coordination services, which receive funds from Medicaid. In FY 2011, LAs across Texas served an average of 12,433 individuals per month, excluding waiver services.

Institutional Services

DADS oversees facilities that provide long-term services and supports to individuals who are older and those with disabilities. NFs 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 intellectual disability requiring residential, medical, and habilitative services.

The NF Program provides services to meet medical, nursing, and psychosocial needs. These services include habilitative services, emergency dental services, and specialized services. In FY 2011, NFs served approximately 56,403 individuals per month through Medicaid. Also in FY 2011, an average of 6,414 individuals per month had their Medicare Skilled NF 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 several hundred. In FY 2011, an average of 5,612 Medicaid-eligible individuals per month received care from community-based ICFs/IID.

DADS operates SSLCs that are certified as ICFs/IID, as a Medicaid-funded federal/state service. SSLCs are campus-based and provide direct services and supports for persons with an intellectual disability. 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.

DADS operates 12 SSLC campuses 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 services at the Rio Grande State Center in Harlingen. In August 2011, 3,994 individuals lived in SSLC-operated facilities.

Guardianship Services

The Guardianship Program provides guardianship services for individuals referred by DFPS 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 65 years of age or older or individuals with disabilities from 18 to 65 years of age, who have been identified by Adult Protective Services as victims of abuse, neglect, or exploitation and who have an indication of incapacity;
- Individuals reaching 18 years of age who have been in a 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 2011, the Guardianship Program served an average of 1,309 individuals per month. Of these individuals, 411 were served by guardianship contractors and 898 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, the 82nd Legislature (H.B. 1, General Appropriations Act, Health and Human Services Commission Rider 61) mandated the creation of the state implement electronic visit verification (EVV). The EVV 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.

EVV was initially piloted in DADS Region 9 (Midland, Odessa, San Angelo and the surrounding areas) beginning on March 1, 2010. On February 1, 2011, the pilot was expanded to include DADS Regions 2 (Abilene, Wichita Falls, and the surrounding areas) and 4 (Longview, Tyler, and the surrounding areas). Additional regions are planned for rollout, with statewide implementation anticipated by December 2013.

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 adjunct 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).

Individuals and agencies participating in the Consumer Directed Services (CDS) option in the services noted above are also required to participate in the initiative.

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, feeding, 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. Plans are underway to conduct a statewide evaluation of direct service worker related issues to inform future policy. Additional initiatives include easier access to training and education, more efficient ways for individuals and families to locate direct service workers, and better direct service worker recognition systems.

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 eight 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 business. 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 such as the DADS Silver Lining program; and
- Distributing information about local services and supports that are available to older adults, people with disabilities, and their families.

As another example, DADS has developed a strong partnership with Sam's Club Pharmacy: The partnership supports the health and wellness of Texans by:

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

Texas Healthy Lifestyles: An Evidence-Based Disease Prevention Grant

Texas Healthy Lifestyles is an evidenced-based project to prevent disease. The project was begun in 2005 with a grant of \$250,000 from the AoA, and it was extended with supplemental grants of \$200,000 in 2009 and \$1.25 million in 2010. The initiative exists to promote healthy aging, improve overall health, and reduce the incidence of emergency room visits and hospital admissions.

Local grantees are in Harris County (Houston), Bexar County (San Antonio), and Bryan/College Station (plus several regions throughout East Texas), Central Texas, Tarrant County, and El Paso. These projects use the Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program (DSMP) models developed at Stanford University to promote physical activities for seniors to enhance strength, stability, and coordination to reduce potentially debilitating falls and to improve overall health.

DADS is working closely with HHSC and managed care organizations to develop protocols for referring Medicaid recipients to CDSMP classes and to explore the feasibility of CDSMP as a covered benefit under the Medicaid program. DADS is also assisting local partners in their process of Diabetes Self-Management Training accreditation and CMS recognition. Local ADRC/AAA partners are collaborating with local Medicare providers to prepare to provide classes which meet the national standards for accreditation. When both accreditation and recognition are achieved, the local partners will be able to seek Medicare reimbursement for the DSMP classes. This will strengthen the capacity for sustainability once the grant ends.

Consumer Directed Services Awareness Initiative

Consumer direction provides alternatives to the traditional model of service delivery for Texas long-term services and supports. The CDS option allows the individual or the individual's legally authorized representative to hire service providers for personal assistance, habilitation, and respite care and, in some programs, providers of professional services. A second option, the Service Responsibility Option, allows the individual or the legally authorized representative a choice in who provides services, but does not require the individual or representative to be the employer of record.

DADS is coordinating a two-part project to increase individual awareness regarding CDS. The first part, completed in May 2011, included a series of eight webinars to educate DADS case managers and ID authority service coordinators about the CDS option, to assist individuals in making a more informed choice about whether to use CDS. This training was targeted toward DADS programs with the lowest CDS participation. DADS is collaborating with HHSC to ensure that the training is adapted for and provided to managed care service coordinators.

The second part of the project was a series of town hall meetings held in ten cities during the summer of 2011. These meetings allowed all individuals enrolled in DADS programs or managed care to learn about the CDS option. To develop the plan and

training materials, DADS included input from stakeholders, including members of the Consumer Direction Workgroup Service Delivery Committee. At each meeting, individuals from the local area shared their experiences with the CDS option.

6.4.2 DADS Goal 2: Regulation, Certification, and Outreach

Target Populations and Service Descriptions

This section gives an overview of the regulatory and quality assurance programs and services provided by DADS.

Regulatory Services

The Department 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:

- NFs,
- Adult day care (ADC) providers,
- Assisted living facilities (ALFs),
- ICFs/IID,
- Home and community support services agencies (HCSSAs),
- HCS, and
- TxHmL.

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 2011 Annual Report” provides data about these DADS services.

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. Survey staff determines if providers are meeting the minimum standards and requirements for licensure and certification, identify conditions that may jeopardize client health and safety, and identify deficient practice areas. When deficiencies are identified and cited, survey staff monitors the provider's plan of correction to ensure areas of inadequate care are corrected and compliance with state and federal requirements is maintained. State licensure and federal certification requirements include numerous enforcement actions that DADS may pursue to encourage providers to correct problems of noncompliance.

By statute, facilities meeting the definitions of NFs, ALFs, ADCs, and privately owned ICFs/IID must be licensed and must comply with all licensure rules to operate in Texas. Publicly operated ICFs/IID, those operated by the state and LAs, 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 Department's licensing and certification review functions. In FY 2011, DADS regulated:

- 1,211 NFs,
- 1,664 ALFs,
- 5,834 HCSSAs,
- 861 ICFs/IID, and
- 497 ADC facilities.

Additionally, DADS conducts annual, on-site reviews of 681 HCS waiver contracts and 188 TxHmL waiver contracts for compliance with the program 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 DFPS findings related to abuse, neglect, or exploitation investigations of individuals who receive HCS, TxHmL, or ICF/IID services.

DADS has oversight, administrative, and regulatory responsibilities related to long-term services and supports for a target population of 4,670,000 individuals who are older or have disabilities. In FY 2011, there were 87,533 individuals living in NFs, 33,182 individuals living in ALFs, and 21,136 individuals receiving services in ADC facilities. Additionally, there were 4,072 individuals receiving services in SSLCs, more than 5,600 people in community ICFs/IID, and more than 20,000 individuals participating in TxHmL and HCS waiver programs.

Licensing and Credentialing Services

When a provider applies for licensure, the division reviews the applicant's history as a provider, obtaining detailed information on operators, owners, and other controlling persons. DADS licensing 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 2011, there were 137,873 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 2011, there were 2,103 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 2011, there were 11,298 active permitted medication aides.

Long-Term Care Quality Outreach

The Quality Monitoring Program

Established by S.B.1839, 77th Legislature, Regular Session, 2001, the Quality Monitoring Program is staffed with nurses, dietitians, and pharmacists who are deployed to provide clinical technical assistance to NFs statewide. Staff schedules visits with NFs to review quality in selected focus areas from 15 evidence-based, best practice topics. The 15 focus areas are directly related to quality of care and quality of life, and they 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 there, and their families.

DADS has expanded the Texas Quality Matters website to include evidence-based best practice reference materials for nursing homes, SSLCs, community ICFs/IID, ALFs, and home and community-based service providers.

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/grs/public/grs.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 quality reviews that include a randomly selected sample of people receiving services. These reports are required by the 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Department of Aging and Disability Services).

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 Quality Review is a statewide survey measuring quality of care and quality of life for people receiving services and supports through home and community-based waiver programs, entitlement programs, community ICFs/IID, and SSLCs. In the past, the reviews have been focused on different programs in different years. Every effort has been made to obtain a representative sample of people receiving services through each program. In the future, the reviews will be conducted every other year and will include responses of people receiving services through all programs. In general, the goal is to sample approximately 380 people per program. If the program is relatively small, the sample size will be reduced, but representative. 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 2011, DADS hosted a symposium on culture change in NFs and a webinar on the topic of the dining experience. The central theme is person-centered and person-directed care that fully aligns with NF regulations and can be accomplished as a low or no-cost strategy. To continue promoting this theme in 2012, DADS plans to host three Webinars and three region-based symposia.

The Positive Behavior Management workshops, presented by the behavior analysis staff from the University of North Texas Behavior Analysis Research Center,

provides professional and direct service staff with information and tools to use when working with individuals with challenging behavior. In 2011, DADS sponsored two workshops, in Houston and Waco. In 2012, DADS will sponsor two workshops in Austin specifically for SSLC staff, and one in Houston for all entities.

Per statutory requirements, an ICF/IID conference is held annually, to assist providers in understanding the survey rules, to review deficiencies commonly found 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 340 participants attended the 2011 ICF/IID conference.

Regulation, Certification, and Outreach Initiatives

Financial Activities Related to Nursing Facility Licensure

Financial problems in the NF industry continue today in Texas and nationally. Costs for food, fuel, and other supplies continue to fluctuate. Credit has tightened, and the U.S. Internal Revenue Service (IRS) has increased its activity related to tax liens and levies.

Thoughtful consideration of the current financial problems in the NF industry includes the potentially far-reaching ramifications of a provider's financial stability. These ramifications can be quite broad and may affect residents' well-being. For example, residents may face food shortages, families may be forced to relocate a loved one to another facility, and communities may face loss of jobs. DADS may be compelled to relocate residents and pay costs associated with the placement of a trustee from the Nursing and Convalescent Home Trust Fund. The trust fund's balance, which is a maximum of \$10 million, could be significantly reduced by the closure of one or more NF providers, and additional assessments could be needed to replenish the fund.

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

- Vendor payment holds,
- IRS levies,
- Financial viability assessment (from the license application),
- Licensed bed occupancy rate change,
- Medicaid bed occupancy rate change, and
- Notices of adverse changes in financial condition.

Investigations Efficiency Project

Regulatory Services is evaluating a project proposal that would increase efficiency in assigning surveyors to complaint and incident investigations as well as assuring timely completion of required reports. The system utilizes notebook and global positioning system (GPS) technology to determine the physical location of surveyors and to assign investigations based on physical proximity to the investigation site. This system allows investigators to use the same notebook to complete a single report template that uploads to the state and federal reporting systems, ensuring timely completion of the report and reducing clerical time required to update both systems. Both travel time and travel costs can be reduced utilizing the immediate assignment of staff based on location. The system can interface with existing voice transcription systems as well as utilizing templates to assure complete data entry. Other capabilities of the system are accessibility of GPS technology for locating investigation sites, tag and transmit capability for photographs, and ability to remotely locate and clean lost or stolen equipment in order to protect sensitive data.

6.5 Internal Assessment

6.5.1 Maintaining Essential Regulatory and State Supported Living Center Staff

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 SSLCs is particularly acute in rural areas. The DADS' workforce is aging with 25.3 percent over the age of 50 and approximately 15.1 percent eligible to retire in the next two to three years. Staff turnover for DADS is 29.9 percent and even higher (33.4 percent) in the SSLCs. 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 Texas state agencies, including DADS. The statewide turnover rate for all state agencies for full-time and part-time classified employees in FY 2009 was 14.4 percent. However, the turnover at SSLCs was even higher, at 34.8 percent. Contributing to this high turnover are

registered nurses at 31.2 percent, licensed vocational nurses at 43.0 percent, psychiatrists at 41.9 percent, psychologists at 30.8 percent and direct support professionals at 45.4 percent.

Professional and technical survey and licensing staff receive training that provides skills in demand in the private sector. An increasing number of employees are leaving state employment in favor of careers in less stressful and more lucrative work environments.

To successfully address the challenges presented by high vacancy and turnover rates, DADS is looking for ways to respond to the labor market and the needs of its current and potential employees. The Department continues to seek innovative ways to recruit and retain employees, with the goal of increasing applicant pools and reducing vacancy rates.

The Department has implemented several management recruitment strategies to increase awareness of job opportunities, 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 colleges and universities;
- Collaborative partnerships with professional health care organizations to increase awareness about career opportunities; and
- Placement of a recruitment coordinator and a recruitment plan at each SSLC.

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 by shifting staff;
- Creation of 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 CMS in order to bring required surveyor training to Texas and alleviate the requirement that surveyors travel to out-of-state training locations.

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;
- Allowing projected filling of positions by facilities to ensure operation at or near 100 percent fill rate; 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 increase retention.

6.5.2 Addressing Infrastructure Needs

Increasing Capacity of DADS Information Technology Resources

The demand for information technology (IT) projects and initiatives to comply with legislative mandates and meet the needs of DADS consumers 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 limitation of resources poses an increasing risk to DADS' capacity to meet future demands to sustain current technology, maintain or improve service levels, and optimize consumer services through technology. To meet demand for day-to-day production support and new development projects, IT staff is augmented through the use of contractors. Increasing contractor costs, particularly for production support, are difficult to sustain, and they limit availability of funds to take advantage of the new Deliverables-Based IT Services contract through the Texas Department of Information Resources (DIR).

DADS program areas need technology to deliver services to the people who depend on DADS. Technology is increasingly important to help existing staff resources be more efficient, effective, and timely in delivering services.

There is an ongoing need to monitor and readily address telecommunications and network bandwidth concerns before they become problems. As more and more applications become automated and web-based, and as the HHSC System moves to cloud-based solutions, proactively providing sufficient bandwidth and response times is critical. DADS will continue to work with HHSC and DIR to address current and emerging bandwidth needs.

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

SSLCs require stable and reliable telecommunication systems, infrastructure, and IT hardware and software to support emerging needs and applications such as the Avatar electronic life record and e-prescribing program.

Continuing to 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 Center 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.

Projects, initiatives, related funding, and operational support resources are needed to address critical initiatives and concerns and problems facing the SSLCs.

- Implementation of the various Avatar modules and components
- Improvements/Expansion for incoming and outgoing trunk lines for the phone system
- Upgrades to support future bandwidth needs at all 12 SSLCs to provide support for business applications and processes
- SSLC cabling infrastructure, as the existing infrastructure is approximately 16 years old and has become very fragile in some locations
- Environmental and security upgrades for server and equipment rooms
- Kiosk furniture replacement/upgrades to accommodate system upgrades
- Purchase, installation, and secure storage of videoconferencing and telemedicine equipment for all SSLCs and at least one state office location
- Equipment for business continuity and disaster recovery (e.g., radios, additional cell phones, active sync devices, tablets, or laptops with air cards for remote access)
- A neutral third party professional assessment of the current and planned Voice over Internet Protocol (VoIP) configuration/ installation to identify performance and maintenance improvements for each facility telephone system
- Assessment of the potential for use of wireless technology at all SSLCs

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

Upon consolidation of HHS System agencies in September 2004, DADS inherited two authorization systems for long-term services and supports: the Service Authorization System Online (SAS) and the Intellectual Disability Client Assignment and Registration (ID CARE) mainframe system. The purpose of these systems is to

enroll consumers in long-term services and supports programs and to verify their services are being provided.

DADS processes billing and payment requests through two separate systems. Billing and payment requests for HCS and TxHmL providers are processed through the ID CARE mainframe system. Billing and payment requests for other DADS programs are processed through the claims management system operated by the Texas Medicaid & Healthcare Partnership (TMHP).

DADS received funding approved by the 81st Legislature for the FY 2010-11 biennium to create a DADS Single Service Authorization System for long-term services and supports. The benefits of creating this system and making system improvements to SAS include:

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

Along with the creation of a Single Service Authorization System, enhancements will be made to automate submission of service authorization documents, such as assessments of individual service plans.

DADS will also integrate billing and payments processing for HCS and TxHmL into the claims management system operated by TMHP. This would increase efficiencies by allowing:

- Use of the same processing rules for all DADS long-term services and supports programs,
- Enhanced federal match for all system modifications and improvements when changes need to be made, and
- More accurate and timely provider payments.

At the end of FY 2013, all long-term services and supports will be consolidated into the Single Service Authorization System, the end of Phase I. Phase II, in the following years, will address all remaining DADS information dependencies and usage between the ID CARE mainframe system and Long Term Care Medicaid information systems. This is necessary to eliminate dependence on outdated and obsolete IT and comply with the CMS Medicaid Information Technology Architecture (MITA) requirements.

CMS has indicated that in the future the state will not receive federal financial participation for antiquated systems that do not meet MITA Standards. This means that future costs for maintenance of information dependencies with the ID CARE mainframe system may not be supported with federal financial participation and would have to be completely supported with state general revenue.

6.5.4 Streamlining Administrative Requirements

Streamlining Contract Management

DADS participates in the HHS System Contract Council, described in section 4.5.3 of this Strategic Plan. The council works to improve contract management across the HHS System, streamlining and standardizing where appropriate. DADS facilitates development of policies and procedures to help implement the council's Improvement Plan, communicating with and seeking input from agency stakeholders, as appropriate.

- DADS will conduct an internal assessment of contract procurement, enrollment, and renewal processes to identify areas for improvement and standardization.
- Once an interagency contract template is developed and approved by the council, DADS will coordinate with internal agency stakeholders to obtain final approval and develop internal policy and procedures for implementation.
- Once the Enterprise Electronic Signature policy is finalized and approved, DADS will coordinate with internal agency stakeholders to obtain final approval and develop internal policy and procedures for implementation.

Administrative Streamlining Reviews

DADS has established an initiative to review each of its programs, in collaboration with external stakeholders, for opportunities to reduce unnecessary or duplicative administrative processes.

For example, during fiscal year 2011, DADS identified opportunities to be more efficient in conducting oversight responsibilities of licensed HCSSA contractors. Contract monitoring reviews are distinguishable from surveys in that they focus on compliance with program, waiver, or contract requirements. Those requirements generally relate to service eligibility and authorization, provision of authorized services, documentation to support billing, provider procurement practices, and prohibitions on using excluded persons as attendants. Surveys focus on compliance with state and federal statutes and regulations. Policies and procedures are reducing duplication by eliminating from contract management reviews areas already covered by Regulatory Services surveys.

Similarly, provider billing compliance, which is reviewed by contract managers, will no longer be routinely reviewed as part of regulatory surveys. Additional changes were made to eliminate duplication in response to investigation of complaints and incidents self-reported by providers. These changes reduce workload for DADS and providers while maintaining appropriate oversight of client services and fiscal accountability.

Effective March 1, 2012, licensure and contracting responsibility for NFs, ADCs, ALFs, and ICFs/IID were consolidated so that initial licensure, change of ownership licensure, and license renewal are processed by the same group that processes

Medicare and/or Medicaid certification and Medicaid contracts. At the same time, a combined licensure/certification/contract application form was created for NF and for ICF/IID providers. Providers will complete one application form and work with one enrollment specialist.

Chapter 7

Department of Assistive and Rehabilitative Services External/Internal Assessment

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. The Department has four program areas: Rehabilitation Services, Blind Services, Early Childhood Intervention Services, and Disability Determination Services. Additionally, the Office of the Deputy Commissioner administers the Autism Program. Through these program areas, DARS provides services that help Texans with disabilities find jobs through vocational rehabilitation, ensure Texans with disabilities live independently in their communities, and help children with disabilities and developmental delays reach their full potential.

The remainder of this chapter is arranged as follows:

- Mission,
- External Assessment,
- Current Activities, and
- Internal Assessment.

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 to enable their full participation in society.

7.3 External Assessment

7.3.1 Developing Innovative Vocational Rehabilitation Service Delivery Strategies to Meet Increased Demand

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

- Ensure policies and services that encourage responsibility and improve access to employment.

Strategic Priority: Encourage partnerships and community involvement.

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

Discussion

Vocational Rehabilitation (VR) helps people with disabilities prepare for, find, and keep employment. The VR program partners with businesses to cultivate new employment opportunities for VR consumers.

Renewal of the Vocational Rehabilitation Process

There are two primary customers served by the VR program: consumers who want jobs and the businesses that hire them. The current VR process must be adapted to meet the demands of business customers for qualified applicants and the demands of consumers for employment that meets their needs. Business partners, consumers and family members all have high expectations for timely services and meaningful outcomes. In order to meet these expectations, DARS is moving beyond the traditional linear, one-size-fits all process to one designed for the realities of today. The goal is to provide market-based career counseling and vocational options, currently in demand by employers, without placing consumers into jobs for which

they do not have an interest. These vocational options must reflect the abilities and interests of the consumer as well as the needs of the current labor market. The improved process will be flexible enough to meet the needs of consumers with more immediate short-term goals for employment while allowing the time necessary for consumers with longer-term career goals to receive needed services. Job readiness should become a more reliable indicator that consumers need to be moved into jobs with a greater sense of urgency.

Increase Collaborations with Agency and Community Partners

There are new opportunities to evaluate and revise what services have historically been purchased from Community Rehabilitation Programs (CRPs), build on integrated relationships with flagship business partners, and develop new partnerships with other agencies that allow for seamless delivery of services and employment for DARS consumers. These opportunities include:

- Simplify processes to focus on results;
- Use federal standards and indicators from the Rehabilitation Services Administration to set minimum standards for CRP performance;
- Incorporate standards of performance in all service contracts;
- Pilot community learning initiatives with the Department of Aging and Disability Services (DADS) through the Money Follows the Person program; and
- Develop more effective partnerships with Texas community colleges

Planned Actions

Texas was one of eight state VR programs to receive a grant from the University of Massachusetts Institute for Community Inclusion, to participate in a Management Learning Collaborative. As a function of the grant, DARS will use the Appreciative Inquiry methodology to renew the VR process by revamping the business plan, policies and processes to reflect a more flexible and responsive program. Appreciative Inquiry is a strategic planning methodology that creates a shared vision for the future that is grounded in successful examples from the organization's past. The pace is dictated by the needs of consumers and business partners. Areas of discussion for strategies will be wide-ranging and will include staff and key community partners.

- **Increase Partnerships with Businesses**—Continue to capitalize on the current trend of businesses eager to hire qualified people with disabilities to build lasting network of employers, loyal to DARS, as a reliable source for qualified applicants, consultation, and technical assistance. DARS will use new cloud-based business relations software to manage this expansion. Collaboration and partnerships with workforce and local chambers of commerce will continue to expand.
- **Improve Business-Transition Linkages**—To build a workforce, many of DARS' business partners have expressed a strong interest in pre-employment training

for high school students transitioning from school to work. DARS needs to connect large and medium-sized business partners with Transition programs to expand the recruiting and training of students who will soon become employees.

- **Leverage Partnerships and Contract Relationships**—Increased demands on Vocational Rehabilitation Counselors time and talents requires the review of several options to establish strategic partnerships in the community.
 - Re-examine, re-evaluate, and revise the contractual relationships with private CRPs for individual placement and supported employment.
 - Continue to develop new opportunities for partnerships and contractual relationships with CRPs and business partners for training consumers at business locations.
 - Maximize the use of state set-aside contract opportunities.
 - Explore, and use to the extent possible, third-party cooperative agreements to grow opportunities with partners. These agreements allow the states to match additional federal dollars within strict established guidelines.
 - Continue exploring the outsourcing of non-core VR functions to current partners.
 - Continue to collaborate with DADS and the Department of State Health Services on serving joint consumers.
 - Use the results from a recently completed work measurement study to determine the best use of VR staff time and potential contracted services.
- **Integrate Transition Services into the Overall VR Strategy**—Staffing limitations necessitate the need to refocus transition strategy from Transition services being provided primarily by Transition Vocational Rehabilitation Counselors to a strategy where school-to-work transition becomes a part of the entire VR program. This may involve developing strategic contractual partnerships with local community providers who can coordinate with DARS and schools to serve students with disabilities.
- **Seek Research/Demonstration Grants**—DARS is considered by many in the country as being innovative in its approach to working with business customers, and DARS is committed to continued improvement. One strategy may be through research and demonstration grants. Universities have expressed an interest in partnering with DARS to pursue demonstration grants to evaluate effective methods for business partnerships.

7.3.2 Ensuring Services are Provided to Children with Complex and Specialized Needs

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

- Ensure children who have intellectual disabilities and/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 Part C of the Individuals with Disabilities Education Act (IDEA) to serve all eligible children under the age of three and provide the services they need. 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.

ECI programs must be prepared to serve children with complex and specialized needs. 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. More children also have specialized needs, intensive medical needs, and auditory and/or visual impairments. Children with complex and specialized needs require more frequent and intensive services.

DARS is challenged to continue to ensure statewide coverage, implement Medicaid and Part C requirements, serve all eligible children, and deliver service levels consistent with regulations within appropriated funding levels. Many states are facing significant challenges as they continue to implement early intervention systems and are struggling to maintain the capacity to deliver the benefits to children and their families. To serve children at greatest risk of disability or significant developmental delay, in September 2011, DARS narrowed the eligibility criteria for children to enroll in the ECI program and increased the requirements for families to share the cost of services. DARS anticipates continued and significant growth in the number of children needing services, even within the narrowed eligibility criteria. In response to these challenges, DARS recently shifted ECI contractor staff training to the web, streamlined processes, and developed a video to demonstrate the role of parents in their child's services.

Planned Actions

DARS will focus on implementing and monitoring the changes identified as part of the program evaluation which began in September 2009. The goal of the evaluation is to develop recommendations for an ECI program that is sustainable and able to effectively serve children and families.

The DARS evaluation and improvement process has several steps that will be implemented in the 2013-17 planning period.

- Monitor the implementation of new eligibility criteria which was effective September 1, 2011.
- Monitor the implementation of new family cost-sharing criteria which was effective September 1, 2011.
- Monitor the significant changes required by contractors for billing Medicaid which were implemented October 1, 2011, and further managed care changes implemented on March 1, 2012.
- Continue to strengthen family cost-sharing through rule-making.
- Continue to clarify, through rule-making, contractor responsibilities for protecting the child and family's rights.
- Implement changes to the program as required by new federal regulations effective October 28, 2011.

7.3.3 Evaluating DARS Capacity to Meet Deaf and Hard of Hearing Needs

Strategic Priority: Encourage partnerships and community involvement.

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

Discussion

DARS Office of Deaf and Hard of Hearing Services (DHHS) works with people of all ages who are deaf or hard of hearing to eliminate communication barriers and ensure equal access and participation in their communities. DHHS maintains a statewide network of community partners and contracted resource specialists to coordinate and facilitate service delivery. These partners and specialists work with other state and local government agencies and the private sector to provide interpreter services, assistance for locating and obtaining assistive devices, advocacy services, empowerment training, interpreter training, and interpreter certification.

The DHHS service delivery system is challenged to ensure the current system is effective in meeting the needs of its consumers. Providing services to persons who are deaf or hard of hearing requires specialized skills and an understanding of the various communication needs of this population. Many service providers struggle to hire qualified staff with the necessary specialized skills which increases the amount of training that must be provided on the job, impacting service delivery. In addition,

in today's economy, service providers are forced to reduce services, especially in rural areas. Often, offices of local providers, housing one or two employees, close due to lack of funding. A key part of interpreter certification and evaluation is assuring that the interpreter tests are valid, which includes the development of specialized tests for situations such as court, trilingual, and medical settings. DHHS specialized interpreter tests have been in use for a number of years and need to be redeveloped for test quality and validation/reliability purposes. For example, there is a need for a court interpreter test which is required by statute but lacks a performance test.

Given the dynamic needs of the deaf and hard of hearing population, it is necessary to seek stakeholder input on whether DHHS is meeting the needs of Texans who are deaf or hard of hearing and to allow stakeholders to share their ideas on how the department can most effectively serve the deaf and hard of hearing community.

Planned Actions

By the end of the 2012-13 biennium DHHS will engage stakeholders to assess the needs of the deaf and hard of hearing population and to consider how DARS is meeting those needs. The deliverable of this priority is an assessment of the current needs of Texas deaf and hard of hearing population, identification of any gaps in the array of services provided by DARS and other entities, and recommendations for future improvements.

7.3.4 Criss Cole Rehabilitation Center Redesign

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

- Ensure policies and services that encourage responsibility and improve access to employment

Discussion

The Criss Cole Rehabilitation Center (CCRC) is a comprehensive vocational rehabilitation training facility operated by the DARS Division for Blind Services (DBS). The mission of the CCRC is to work in partnership with consumers toward the goal of employment and independent living. Training is provided in a residential/community setting.

In recent years, CCRC management has been considering new ways to improve programming and service delivery to its customers to further their employment goals and enhance the quality and outcomes of their experience. The CCRC Redesign proposal has been presented to the National Federation of the Blind of Texas, the

American Council of the Blind of Texas, the American Federation for the Blind, the DARS Council, the Rehabilitation Council of Texas, the Texas Rehabilitation Association Network, and the Lighthouse Industries for the Blind of Texas. Their feedback and recommendations have been incorporated into an approach for program redesign. Twelve areas of focus were identified, and a workgroup has been created to address each area. The goal of the redesign is for consumers to experience individually-tailored, intense programming so that they will realize their desired employment goals more quickly and satisfactorily.

Planned Actions

The new approach allows adults who are legally blind to choose from three programs that meet individual training needs and preferences.

Consumers who participate in the seven-week **Confidence Building Program** can expect to gain self-confidence and further independence. Consumers will participate, learn, and gain valuable skills as they come to understand how blind individuals can achieve their life goals, including competitive employment.

The **Proficiency Program** helps consumers identify and obtain the skills needed to achieve career and independent living goals.

The **Career Focus Training Program** helps consumers continue to develop and refine the skills necessary to achieve academic and/or career goals. Consumers identify a realistic vocational goal and become ready for an intensive program.

Expected outcomes and impacts of the redesign include:

- Produce quicker results—consumers graduate sooner.
- Increase program intensity—consumers gain confidence and skills earlier.
- Optimize technology throughout program—consumers can functionally use technology faster.
- Enhance employment focus—consumers will be better qualified applicants.
- Enhance individual customization of programming—consumers demonstrate an understanding of relationships between training activities and their individual vocational goals.
- Increase partnerships with field staff and consumers—increased referrals, field satisfaction, and achievement.

The redesigned programs will be piloted beginning in June 2012 and continue throughout the planning period.

7.3.5 Monitoring and Responding to Changes in Federal Funding

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

- Ensure policies and services that encourage responsibility and improve access to employment.

Discussion

The federal Budget Control Act of 2011 was signed into law in August of 2011 and involves the introduction of several complex mechanisms, such as the creation of the Congressional Joint Select Committee on Deficit Reduction and options for a balanced budget amendment. The Committee's failure to produce a bill identifying budgetary savings of at least \$1.2 trillion over federal fiscal years (FFYs) 2012-21 has triggered an automatic spending reduction process that includes sequestration, a form of automatic cuts that apply largely across the board, to take effect in January 2013. For subsequent fiscal years, the discretionary spending reductions are achieved through a downward adjustment of statutory limits on discretionary spending divided into two new categories—defense and nondefense spending.

Planned Actions

According to projected impacts, several of DARS' federal grants, such as VR and ECI, could be impacted by as much as an 8.8 percent reduction. DARS will:

- Monitor the federal government's actions on the budget for FFY 2013 and beyond, and
- Monitor the appropriations process for changes to funding and explore additional opportunities to maximize current dollars.

7.4 Current Activities

7.4.1 DARS Goal 1: Children with Disabilities

Early Childhood Intervention Services

Target Population

The ECI program serves families with children birth to 36 months with developmental delays or disabilities. ECI services are available to all eligible

children. Children are eligible for comprehensive ECI services if they meet any of the following criteria:

- A medically diagnosed condition that has a high probability of resulting in a developmental delay;
- A developmental delay that affects functioning in one or more areas of development including cognitive, communication, motor, social-emotional, and adaptive/self-help; or
- An auditory or visual impairment as defined by the Texas Education Agency.

The ECI program has seen significant growth in the number of children served over the past several years. In state fiscal year (FY) 2011, comprehensive services were provided to 59,092 children with developmental disabilities or delays.

The growth in demand for services can be attributed to the increase in:

- Births of children who meet the criteria for the program,
- Survival rates of these children, and
- Awareness of early brain development and the importance of early intervention for needs that arise.

More and more children have developmental delays or impairment in hearing or vision. One factor is premature births, which are increasing. A related factor is low birth-weights, which is also increasing. Prematurity is a major determinant of illness and disability among infants, including developmental delays, chronic respiratory problems, and vision and hearing impairment. Data from the National Center for Health Statistics indicate that the rate of infants born pre-term increased by more than 7 percent from 1998 to 2008. In 2008, one in eight infants (13.3 percent of live births) was born pre-term. In that same year, one in 12 infants (8.4 percent of live births) was born with low birth-weight.

Of the children eligible for ECI services due to 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. More children also have specialized needs, related to autism, intensive medical needs, and substantiated abuse or neglect. Progress in medical and other treatment is increasing the survival rates of children born with medical problems or complications. Further, with early intervention services, many children attain significant and lasting developmental progress and achieve positive developmental outcomes.

Thanks in part to more research on children's brain development and the effectiveness of early intervention, parents and caretakers are more aware of the challenges that can occur and the need for early intervention. Accordingly, interest in ECI services has increased.

Service Description

ECI provides family support and specialized services to strengthen the family's ability to access resources and to improve their child's development through daily activities.

- **Referral**—Anyone can refer children to ECI. Most referrals come from the medical community or directly from families. Other sources include the Department of Family and Protective Services, childcare providers, hospitals, family friends, social workers, or others familiar with the child and with early intervention services.
- **Evaluations and Eligibility Determinations**—For children with delays, a comprehensive evaluation determines the type and extent of the delay to order to determine eligibility.
- **Individualized Interdisciplinary Planning Process**—Once eligibility is determined, an interdisciplinary team that includes the family develops an individualized family service plan.
- **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**—Through service coordinators, ECI programs provide case management for all members of the child's family as their needs relate to the child's growth and development.
- **Familiar Settings**—Most ECI services are provided at home, but they can also be provided in other places where children typically learn, live, and play, and where children without disabilities participate in daily activities, such as a childcare center, a neighborhood park, a library, or other community settings.
- **Transition**—ECI services end when the child turns three years of age. 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 families. For children needing further intervention services, the goal is a smooth transition with no service gaps.

As required by the IDEA, Part C, the following comprehensive array of services is available.

- Assistive technology (services and devices)
- Audiology
- Case management
- Early identification, screening, and assessment
- Family counseling
- Family education
- Medical services (diagnostic or evaluation services used to determine eligibility)

- Nursing services
- Nutrition services
- Occupational therapy
- Physical therapy
- Psychological services
- Social work services
- Specialized skills training
- Speech language therapy
- Vision services

In FY 2011, services were provided through 56 community-based programs. These programs include the following types of public and private community-based organizations:

- 27 community/state local centers,
- 16 non-profit service organizations,
- 7 regional educational service centers,
- 4 local independent school districts, and
- 2 other agency types.

Services for Blind Children

Target Population

The Blind Children's Vocational Discovery and Development (BCVDD) program focuses on services for children from birth through age nine. Youth ages ten and older are referred to the DBS Transition Services program. However, the BCVDD program continues to provide services for those children ages 10-21 who do not meet the eligibility criteria for the Transition Services program.

As noted above, the population of children with disabilities is increasing, and this increase includes an increase in the number of children who are blind. The number of babies born in the United States (U.S.) with severe visual impairments and blindness is increasing.¹ Population data for the planning period indicates that there are currently approximately 79,000 children with blindness and visual impairment in Texas, and this number is expected to increase to approximately 83,000 by 2017.

With advances in modern technology, more babies with multiple disabilities are surviving. Additionally, the Texas Education Agency, a primary source of referrals to the program, reports an increase in the number of blind and visually impaired children who receive special education services. Severely visually impaired children, many of whom have other multiple disabilities, have complex needs and

¹ Brigitte Volmer, et. al., "Predictors of Long-term Outcome in Very Preterm Infants: Gestational Age Versus Neonatal Cranium Ultrasound," *Pediatrics*, November 2003.

require a variety of service delivery options. Service specialists face multiple challenges when delivering the array of services these children and their families require and must have comprehensive knowledge of resources, disabilities, interventions, training, assistive technology, and support systems.

The program served 4,068 children in FY 2011, an increase of 6 percent. Due to increased networking with special education providers, program referrals have increased.

Service Description

The BCVDD Program helps children who are blind or severely visually impaired to increase the skills required for personal independence, potential employment, and other life pursuits. The program emphasis is on serving children who are permanently and severely visually impaired.

Specialized services include counseling and guidance for children and their parents for:

- Adjustment to blindness and its impact on development,
- Educational support,
- Information and referral,
- 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 provides services for children ages three through eight who have an autism spectrum disorder (ASD). The autism spectrum includes diagnoses of:

- Autistic Disorder,
- Pervasive Developmental Disorder – Not Otherwise Specified,
- Rett's Disorder,
- Asperger's Disorder, and
- Childhood Disintegrative Disorder.

ASD is the fastest-growing serious developmental disability in the U.S., currently affecting an estimated one percent of children, and is felt by some to be a national

health emergency.² The Centers for Disease Control and Prevention (CDC) reported that in 2006, approximately 1 in 110 children in the U.S. had a diagnosis ASD. Recently released data from the CDC note an increase to 1 in 88 children with ASD. Based on these new numbers, in Texas in 2012 it is estimated that there are more than 26,000 children ages 3 through 8 with ASD. That number is projected to increase during the planning period, growing to approximately 28,000 in 2017.

Service Description

The Autism program provides the following services, as determined by the individual needs of the child.

- Assessments
- Applied behavior analysis treatment
- Audiology evaluations
- Psychological testing
- Speech-language therapy
- Physical therapy
- Occupational therapy
- Home-based services

Autism services are provided by the following contractors:

- Autism Treatment Center, San Antonio
- Center for Autism and Related Disorders, Austin
- Child Study Center, Fort Worth
- Easter Seals North Texas, Dallas
- MHMRA of Harris County, Houston
- Texana Center, Rosenberg

The DARS Autism Program was developed as a pilot project in FY 2008. Initially, the pilot served two geographic areas of Texas: Houston and Dallas/Ft. Worth. Subsequent increases in funding from the legislature allowed the program to expand to two additional geographic areas (Austin and San Antonio). In other areas of the state, services are not yet available through this program.

² January 28, 2011 -- U.S. Department of Health and Human Services 2011 Interagency Autism Coordinating Committee Strategic Plan for Autism Spectrum Disorder Research

7.4.2 DARS Goal 2: Persons with Disabilities

VR and independent living (IL) services for adults and youth are available for people with general and visual disabilities. DARS also serves Texans who are deaf or hard of hearing.

Vocational Rehabilitation Services

The VR program provides services for eligible individuals consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. The program offers a variety of skills training, accommodations, and adaptations, which are tailored to each consumer's skills, abilities, and interests. The principle of informed consumer choice guides the provision of services, with the ultimate goal of helping consumers function as independently as possible in employment, consistent with their skills, abilities, and interests.

Vocational Rehabilitation - Blind

Target Population

The DARS DBS assists Texas adults and youth who are either blind or significantly visually impaired, to meet their employment and independent living needs. The program served 10,425 blind people in FY 2011.

The Texas population growth has a direct impact on the blind and visually impaired population. The number of people potentially eligible for VR-Blind services is estimated to increase significantly during this planning period, from approximately 124,500 persons in FY 2012 to approximately 138,000 in FY 2017.

The increasing prevalence of diabetes is a factor in the increasing number of people with blindness. In 2009, approximately 1.7 million people in Texas had a diagnosis of diabetes, and some experts project that the total number of diabetes cases in Texas will increase to nearly 3 million by 2040. People with diabetes have a greater risk of experiencing vision loss from diabetic retinopathy, cataracts, and glaucoma. Each year, as many as 25,000 people become blind as the result of diabetic retinopathy. Diabetes is the leading cause of blindness for adults ages 20 to 74.

Diabetes affects ethnic groups differently, with African Americans and Hispanics having higher prevalence rates than Anglos. The increase in the Hispanic population will cause an increase in diabetes rates unless trends change. Fortunately, significant improvement is possible through rehabilitation programs educating people about diabetes self-management skills, nutrition counseling, and exercise programs.

Service Description

A sense of empowerment is key to a consumer's success in employment and living independently. It is critical for the consumer to have a positive attitude, high

expectations, and mastery of basic blindness skills. The ultimate goal of the rehabilitation program is to help consumers to use all the options available and to instill in them the confidence to move ahead independently with employment and life.

The VR-Blind program provides work-related services for eligible individuals consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. The VR counselors work with a variety of sources to ensure that individuals gain the independent living skills, experience, training, and education to reach their employment outcome.

Some of the available specialized services are listed below.

- 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
- Intermediary assistance with existing and potential employers

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.

For individuals with the most severe disabilities, supported employment services are provided to help consumers obtain competitive employment. Specially trained job coaches/trainers provide consumers with individualized, ongoing support needed to maintain employment. Program enhancements have been introduced to further promote successful employment for this target population.

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 and relationship within the environment. Mobility is the act of moving in the environment with use of an established tool, e.g., a white cane, dog guide, or electronic navigation device.

Transition Services provide age-appropriate VR services to eligible youths ten years of age and older, to support them in making informed choices about their future.

The program served 1,992 youth in FY 2011, preparing them for secondary education, vocational training, integrated employment including supported employment, continuing education, independent living, and/or community participation.

The **Business Enterprises of Texas (BET)** program develops and maintains business-management opportunities for legally blind persons in food-service operations and vending facilities located on public and private properties throughout the state. This program assisted 97 individuals in food service employment in FY 2011. BET continues to receive a large number of applications, which requires the program to increase the number of new food service facilities by two each year. In addition, facilities with aging equipment or changes in the scope of business must be refurbished. BET is entirely funded by revenues generated from vending machines on state property.

The **Criss Cole Rehabilitation Center**, located in Austin, is the agency's comprehensive rehabilitation facility serving blind people from Texas and from other states. Services are typically provided in a residential setting. At the center, consumers receive individualized, intensive VR-Blind training and support, to develop the confidence, skills, and techniques to seek employment, enroll in college or vocational training, or pursue other opportunities commensurate with their goals. This program served 405 individuals in FY 2011.

Use of consumer technology is of growing importance in the business world, and it is critical that consumers be able to use these portable devices to fully participate, engage, and compete in the world of work. Consumers trained in older technologies may encounter difficulties in work environments that use technologies more current than what they learned and used during training. The Criss Cole Center trains consumers in using devices with accessibility features enabling the user who is blind to use all features of the mobile device to electronically communicate "barrier free" in the work or educational setting.

Vocational Rehabilitation - General

Target Population

To be eligible for the VR-General program, an individual must:

- Have a physical or mental impairment that constitutes or results in a substantial impediment to employment;
- Require VR services to prepare for, enter, engage in, or retain gainful employment consistent with the consumer's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice; and
- Be able to get and keep a job after receiving services.

Individuals who receive Social Security Disability Insurance and Supplemental Security Income disability benefits are presumed eligible for VR Services.

It is estimated that in 2012 there were approximately 1,000,000 people with disabilities in Texas who may be potentially eligible for VR services, and this figure is projected to increase to more than 1,100,000 by 2017.

In FY 2011, more than 91 percent of the consumers served in the VR-General program had significant disabilities. The range of disabilities that interfered with their employment included:

- 22 percent with cognitive disabilities,
- 22 percent with musculo-skeletal disabilities,
- 18 percent with mental/emotional disabilities,
- 12 percent with deafness or other hearing disorders,
- 5 percent with neurological disabilities,
- 3 percent with substance abuse disabilities,
- 3 percent with traumatic brain/spinal cord injuries,
- 2 percent with cardiac/respiratory/circulatory disabilities, and
- 13 percent with other impairments.

Injured employees who receive letters from the Texas Department of Insurance Division for Workers' Compensation continue to be a large potential VR referral population. Counselors contact potential consumers to determine whether or not VR services are appropriate and to assist in their timely return to work. This contact could have a significant financial impact for individuals and those entities that assist persons who continue to be unemployed because they do not receive the services needed to return to work. However, contacting injured employees to make this determination requires a specialized level of experience, skill, and time commitment beyond the current capacity of general VR counselors.

Service Description

The VR-General program, a state-federal partnership since 1929, 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.

Work-related services are based on individual needs and may include a variety of services.

- 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 working world
- Training to learn job skills in trade school, college, university, on the job, or at home

- Hearing examinations, hearing aids, and other communication equipment, aural rehabilitation, and interpreter services for the deaf and hard of hearing
- Medical treatment and/or therapy to lessen or remove the disability
- Assistive devices such as artificial limbs, braces, and wheelchairs to stabilize or improve functioning on the job or at home
- Rehabilitation technology devices and services to improve job functioning
- Training in appropriate work behaviors and other skills to meet employer expectations
- Job placement assistance to find jobs compatible with the person's physical and mental ability
- Supported employment services
- Follow-up after job placement to ensure job success

The principle of informed client choice guides the development of the consumer's plan. After the Individualized Plan for Employment is developed, counselors use case service funds to purchase services needed to achieve the employment goal. VR staff continues to expand employment opportunities for consumers through active outreach to businesses in Texas who hire qualified individuals with disabilities.

As a result of services provided by the VR-General program, consumers found employment in a variety of occupations.

- 24 percent in service industries, such as cosmetology and personal care
- 18 percent in office and administrative support
- 9 percent in health care practitioners, technical, and health care support
- 9 percent in transportation and material-moving
- 8 percent in education, legal, community services, arts, and media
- 8 percent in production
- 8 percent in sales and related occupations
- 6 percent in management, business, and financial
- 4 percent installation, maintenance, and repair
- 3 percent in construction and extraction
- 2 percent in computer, engineering, and science
- 1 percent in all other occupations

The dual customer approach—treating business and the consumer as a customer—provides employment outcomes in a more timely and cost effective manner. DARS is one of 80 public VR programs that have adopted the dual customer model promoted by the Council of State Administrators of Vocational Rehabilitation. Each VR program has a business consultant, and together these consultants form the National Employment Team (NET). DARS and other NET members initiate local and state business relationships, and some of these become national relationships.

This larger business network creates the potential for many NET members to benefit from an individual member's initiative.

Businesses are actively reaching out to DARS for assistance to hire qualified employees with disabilities. Although employers may have interest and enthusiasm, they often are not sure how to go about recruiting or supporting candidates with disabilities. That is where DARS steps in to learn what the business's needs are for hiring. In many cases the employer's initial need might be for disability awareness training. That interaction often opens the door for consultation or technical assistance on a reasonable accommodation and can eventually lead to hiring. Businesses want to partner with DARS for a number of reasons, including interest in diversity, the economic climate, and a shortage of workers. Some employers have seen the success of other companies that have hired people with disabilities and want to achieve the same success. Partnering with the DARS VR program to hire a qualified applicant who has a disability is a good business decision that can reduce recruiting and training costs, offer tax incentives and benefits, and result in lower turnover rates.

As part of the VR program, counselors provide transition planning services to eligible students with disabilities to assist with the transition from high school to employment or further education. These counselors actively seek students with disabilities who are enrolled in regular and/or special education, to provide them information about the availability of VR services. Currently, the VR program has 99 positions dedicated to transition services in high schools. These Transition Vocational Rehabilitation Counselors (TVRCs) work in approximately 460 predominately larger high schools, out of the 1,765 public high schools in Texas. There are liaison counselors who work with all other high schools. Each region also has a Regional Transition Program Specialist available to TVRCs to facilitate cooperation with local school districts and other state agencies promoting transition-planning services. In Texas, 7,534 students were served during FY 2011.

To improve students' transition success, DARS is focusing on strategies for integrating transition services into general VR services, as discussed in this Strategic Plan's *Section 7.3.1, Developing Innovative Vocational Rehabilitation Service Delivery Strategies to Meet Increased Demand*. The Division of Rehabilitation Services (DRS) is building business relations and seeking demonstration grants where appropriate.

Further, transition continues to be a focus of VR, and all federal Workforce Investment Act reauthorization proposals include stronger outcomes and dedication to transition services. DARS transition efforts will focus on:

- Reinforcing transition services and strategies,
- Improving partnerships with schools, and
- Maximizing TVRC utilization in the schools.

As DARS continues to strengthen its transition strategies, the agency has the opportunity to fully integrate transition strategies through business relations and to ensure that school-to-work transition becomes a part of the entire VR program, which will lead to better services and more successful outcomes.

Independent Living Services

IL consumers are people who have significant disabilities resulting in a substantial impediment to their ability to function independently in the family and/or community. These individuals face barriers that severely limit their choices for quality of life. Some barriers are obvious, such as a curb with no ramp for people who use wheelchairs or a lack of interpreters or captioning for people with hearing impairments. Other barriers are often less obvious and can be even more limiting, such as inadequate or inaccessible housing, attendant care, or transportation. Unfortunately, misunderstandings about disability can also be barriers, limiting people with disabilities from living independent lives in their communities.

The Texas population is increasing in numbers, and because people are living longer, the average age is increasing, which means that more people experience disabilities. Thus, the number of applicants to the Independent Living Services (ILS) program is steadily increasing. The cost of services, especially medical services, is increasing significantly each year. Assistive technology, which enables consumers to live independently, is becoming more sophisticated in addressing more kinds of functional needs, and it is becoming more expensive.

Independent Living Services – Blind

Target Population

The ILS-Blind program is available to adults of all ages whose independence is threatened because of vision loss. The predominant potential consumer group includes individuals who are older, or no longer able to work, and who are experiencing serious limitations in their functional capacities because of severe visual loss. Likewise, blind individuals who have returned to the community from institutional settings find the adjustment and adaptive techniques offered by this program beneficial. To the extent that Texans who are blind or visually impaired live independently in their homes and communities, the need for publicly funded nursing care and assisted living is reduced.

In FY 2012, it is estimated that approximately 269,000 blind people in Texas would experience challenges with daily living: dressing, bathing, getting around the home, and going out alone. This population is projected to increase to approximately 300,000 in FY 2017. In FY 2011, the program served 3,493 people.

Program growth increases caseload sizes. IL workers can provide effective and timely services with a caseload size at or below 70 for full time caseloads. The statewide caseload average is within the target caseload size; however, several caseloads in regions of Texas are significantly higher including Fort Worth, Waco,

Tyler, San Antonio, and Houston. Caseloads exceeding the targets are difficult to manage, resulting in an uneven distribution of services to consumers.

Service Description

The ILS-Blind program offers specialized services to help people avoid institutionalization and remain in the community. Services build confidence in living independently, primarily through adjustment to blindness and learning alternate ways to do daily tasks. A variety of services address the amount and kind of assistance needed, including:

- Information about vision loss, adjustment to blindness, adaptive techniques, and special resources related to vision loss;
- Referral to other community resources related to aging, disability, and other individualized concerns;
- Group training to increase self-confidence and to provide opportunities for “hands-on” application of adaptive techniques for everyday activities;
- One-on-one, in-home training in adaptive skills; and
- Peer support development.

Independent Living Services - General

Target Population

ILS-General serves people who have challenges to their independence or persons with significant disabilities. In FY 2012, it is estimated that approximately 875,000 persons may be eligible for ILS-General services, rising to almost 970,000 by 2017.

Service Description

IL services contribute to the independence of people with disabilities in the community and offer support for their movement from nursing homes and other institutions to community-based settings. A broad array of services promote increased self-sufficiency and enhanced quality of life. Services include counseling and guidance, durable medical equipment, communications aids, prostheses, rehabilitation technology, and IL skills training.

Services are provided by both the DARS ILS-General program and the Centers for Independent Living (CILs) which receive funding from DARS.

At CILs, consumers control the decision-making, service delivery, and management of these community-based organizations, promoting practices that increase self-help, strengthen individual and self advocacy, and actively develop peer relationships and role models. CILs play an important role as a critical link to the service delivery systems of other health and human services programs in local communities and provide expertise in navigating the array of community services that otherwise may not be discovered by a person with a severe disability. Currently, there are 26 CILs in Texas, covering a small portion of the state.

The number of applicants to the IL services program is steadily increasing. Compounding the increased demand for services is the rapid expansion of the CILs. When consumers need services beyond those provided by CILs, they are referred to the ILS-General program. IL counselors also spend time supporting multiple CILs, which decreases the time available to serve other consumers on their caseload. In addition, DARS provides technical assistance and oversight to any CIL receiving state funds.

Comprehensive Rehabilitation Services

Target Population

The Comprehensive Rehabilitation Services (CRS) target population includes people with traumatic brain injury and traumatic spinal cord injury who require a special set of services. The CRS program projects the number of people potentially needing the program's services will grow from approximately 7,300 in FY 2012 to 7,400 in 2017.

Service Description

The CRS program was created in 1991 for people with traumatic brain injury and traumatic spinal cord injury, to increase an individual's ability to function independently within the family and the community. The program services include:

- Inpatient comprehensive medical rehabilitation,
- Outpatient rehabilitation services, and
- Post-acute brain injury rehabilitation services.

These time-limited services are designed to assist the consumer with daily living skills and to prevent secondary disabilities.

The CRS program budget has grown from \$1 million when the program began in FY 1991, to almost \$25 million in FY 2012. The 82nd Texas Legislature increased the percentage share of dedicated revenues that DARS may use to provide CRS services. This change is projected to increase available CRS funding by \$7.3 million in FY 2012. DARS hopes to serve as many consumers as possible as soon as possible, and the agency is working with the provider community to increase program capacity to meet the need for CRS services.

DARS will be evaluating the CRS program service delivery model in light of increases in funding and will engage stakeholders, including elected officials, to ensure a comprehensive evaluation occurs.

Blindness Education, Screening, and Treatment

Target Population

The Blindness Education, Screening, and Treatment (BEST) program target population includes adult Texans who may be at risk for blindness because of

untreated eye medical conditions such as diabetic retinopathy, glaucoma, and detached retina. In FY 2011, 1,745 individuals received vision screenings, and 93 received eye medical treatment.

Service Description

Created in 1997, the BEST program is designed to prevent blindness. The program encourages Texans to take care of their eyes, provides adult vision screening services to identify conditions that may cause blindness, and pays for urgently needed eye medical treatment for adults who do not have health insurance or other resources to pay for the needed treatment. This assistance helps Texans retain employment and support their families while saving federal and/or state funds that would otherwise be needed for rehabilitation and/or social services if blindness occurred. The BEST program is funded by Texans who donate a dollar when they renew their driver's license or state-issued identification card.

By encouraging Texans to take care of their eyes and to seek professional care if they are at risk for potentially serious eye conditions and by assisting with medical treatment to prevent blindness, BEST helps Texans retain employment and supports their families while saving federal and/or state funds that would otherwise be needed for rehabilitation and/or social services if blindness occurred.

Deaf and Hard of Hearing Services

Target Population

The DARS DHHS serves Texans who are deaf or severely hard of hearing. DARS estimates that there are approximately 913,000 persons in Texas in 2012 who meet these criteria; this is 3.5 percent of the population, based on the U.S. Census Bureau's American Community Survey. DARS projects this population will grow from approximately 913,000 in FY 2012 to approximately 1,000,000 in FY 2017. As the population of individuals who are deaf or hard of hearing in Texas grows, so does the need for services.

Service Description

The DHHS office promotes an effective system of services for individuals who are deaf or hard of hearing, and it evaluates and certifies interpreters. To facilitate the provision of specialized services to individuals who are deaf or hard of hearing, DARS contracts with community-based organizations that provide communication access and other services designed to remove barriers between individuals needing services and service providers in the communities. Some DHHS consumers are people who have suddenly lost their hearing as adults, resulting in immediate communication challenges such as when they no longer know the phone is ringing or when someone is at the door or if someone such as a child is calling for help.

A variety of services are provided, through community-based organizations, to enable individuals to express their freedoms, participate in society to their individual potential, and reduce their isolation.

- Advocacy
- Outreach and education
- Youth training
- Interpreter services
- Adjustment and hearing technology services for persons experiencing hearing loss
- Computer Assisted Real-Time Transcription Services
- Interpreter training, including Hispanic trilingual training and certified deaf interpreter training
- Service provider training regarding the provision of services to individuals who are deaf or hard of hearing
- Information and referral services
- Vocational education and independent living services for individuals who are low-functioning deaf or hard of hearing
- Services to older persons to bridge communication barriers and reduce isolation

Another area in which DHHS serves the deaf population is the interpreter certification program, which tests and rates interpreters for the deaf, issuing certificates as appropriate. DARS certifies interpreters of varying levels of skill and maintains lists of certified interpreters for courts, schools, service providers, and other interested entities. There are currently 1,542 certified interpreters in the state. The demand for qualified interpreters is prompting more interpreter test candidates to apply.

Most interpreting situations require advanced levels of proficiency, and only 46 percent of interpreters are certified at advanced levels. Only 135 interpreters certified by DARS are certified for court proceedings. In 2010, DARS began certifying Hispanic trilingual interpreters. To date, there are ten certified Hispanic trilingual interpreters. Enhancing the skills of certified interpreters is vital to ensure availability of certified interpreters and certified court interpreters in Texas. Interpreters assist in the facilitation of communication that directly impacts activities of persons who are deaf or hard hearing in daily life and for those involved in court proceedings.

DARS also administers the **Specialized Telecommunication Assistance Program**, authorized by the 75th Legislature. This voucher program, funded by the Universal Service Fund, provides telecommunication access equipment for persons who are deaf or hard of hearing, who are speech impaired, or who have any other disability that interferes with telephone access. During FY 2011, more than 28,000 vouchers were issued, of which 75 percent were for amplified telephones.

7.4.3 DARS Goal 3: Disability Determination

Disability Determination Services

Target Population

For Social Security purposes, disability means a medical condition preventing a person from working, or in the case of a child, preventing the child from engaging in age-appropriate activities. To meet the definition, the medical condition must be so severe that it will last at least twelve continuous months or result in death, and it must be documented by objective medical evidence.

DARS Disability Determination Services (DDS) administers two disability determination programs on behalf of the Social Security Administration (SSA). The first program, Social Security Disability Insurance (SSDI), is related to work. Workers earn coverage for themselves and family members by paying Social Security tax. The program covers workers who have a disability, widows/widowers who have a disability, and workers' adult children who have a disability.

The second program, Supplemental Security Income (SSI), is related to means—how much or how little a person earns and owns. People who meet the criteria for disability and have low incomes and few assets may qualify for SSI benefits, which supplement SSDI benefits.

Service Description

When a person is not able to work due to a physical or mental impairment, that person may apply for federal SSDI and/or SSI disability benefits. DDS processes the applications for these benefits under an agreement between the state and SSA. SSA provides 100 percent of the funding.

Each application for SSDI/SSI disability benefits originates in an SSA field office and is forwarded to DDS. There, it is developed and adjudicated by a trained Disability Specialist who reviews the disability forms and gathers medical evidence from the claimant's treating sources. Usually the specialist receives enough evidence from the applicant's medical sources to make a decision. If more evidence is needed, a consultative examination is arranged and paid for by DDS with funds from the SSA.

The specialist and a DDS medical consultant team review all the information and determine whether an applicant is disabled as defined by SSA. In FFY 2011, the DDS processed 257,949 initial cases, up from 209,817 in FFY 2009. DDS determined that 97,247 people, or 37.7 percent, met the SSA criteria for disability, up from 89,044 people, or 43.5 percent, in 2009.

For quality control, SSA reviews a sample of initial DDS determinations. In FFY 2011, DDS achieved a 97 percent accuracy rate compared to the national average rate of 95.5 percent. After completion of the DDS adjudication process, the case is returned to the Social Security Field Office from which it was received, and the

applicant is notified of the decision by mail. In FFY 2011, the Texas DDS average processing time for an initial case was 84.8 days compared to the national average of 89.4 days.

Applicants who have been denied benefits may request reconsideration, the first step in the appeal process. Reconsideration cases are reviewed in the DDS by a different specialist and doctor from those who processed the initial application. In FFY 2011, the DDS reviewed 70,295 reconsideration cases, of which 10,544, or 15 percent, were allowed, or reversed.

The DDS allowance rates for both initial and reconsideration cases were higher than the national average in FFY 2011. The national allowance rate for initial cases was 33.3 percent, and for reconsideration cases, it was 11.6 percent. This means that, in percentage terms, the Texas DDS determined claimants to be “disabled” at a rate above the national average. SSA has final authority to award or deny benefits.

Benefit Amounts as Reported by SSA

As of December 2010, Texans who have been determined disabled by SSA receive \$805.6 million combined SSDI and SSI disability payments each month. This does not include an additional \$42 million paid each month to spouses and children of those determined disabled.

Adjusting to Increase in Disability Applications

DDS is adjusting to the increase in the number of SSA disability claims by realigning and redistributing staff in light of the federal hiring freeze that prevents the DDS from filling Disability Specialist positions as they become vacant. National disability claims rose 7 percent in FFY 2011 to more than 4.8 million, according to the SSA. In Texas, the claims rose 6 percent in 2011, to 367,599.

7.5 Internal Assessment

7.5.1 Continuous Improvement of Business Processes

Pursuing Grant Opportunities

DARS is strengthening its approach of working with business customers through research and demonstration grants, which allow helpful flexibility in the use of funds. These additional funds are especially important as regular VR funding remains flat or decreases while costs continue to rise. Historically, a portion of VR funding has been used to establish innovative programs and may now be needed to maintain core services. The Virginia Commonwealth University Rehabilitation Research and

Training Center has expressed a strong interest in partnering with Rehabilitation Services to pursue demonstration grants to develop methods for:

- Effective business partnerships,
- Development of indicators for consumer success with specific jobs within a specific company, and
- Training for businesses in adapting work context for people with intellectual disabilities.

One example of this effort is Project HIRE, a five-year grant recently received by DARS and funded by the Texas Council for Developmental Disabilities, to support individuals with severe developmental disabilities who want to pursue post-secondary education and employment. Through this grant, DARS will provide extensive wrap-around services, such as one-on-one educational coaches, to support six consumers through the first grant year and a minimum of ten consumers in subsequent years to participate in higher education—with a continuing education certificate, vocational certificate, or degree from South Texas College—and in finding employment. This grant will serve primarily low-income and Hispanic consumers from the DRS-McAllen Unit in the underserved area of Hidalgo County.

Building Capacity to Serve the Deaf-Blind Population

People who are deaf-blind experience challenges in all aspects of everyday life. They must find individual ways to communicate, navigate their surroundings, and find 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. With growth in the populations of older people and children born prematurely, the number of individuals who are deaf-blind will also increase significantly.

Advances in communications technology—such as telecommunications, Internet service, and other advanced communications—have given people new ways to find employment, purchase products, and engage in the civil and social life of their communities, and these benefits have remained largely unavailable to or inaccessible for the growing numbers of people who are deaf-blind.

To increase the technology available to persons who are deaf-blind, the Federal Communications Commission has established a National Deaf-Blind Equipment Distribution Program to distribute specialized equipment to low-income individuals who are deaf-blind. The Perkins School for the Blind, in partnership with Helen Keller National Center for Deaf-Blind Youths and Adults (HKNC), is the certified program to serve Texans eligible for the program. To provide access to the equipment and services, the program will conduct outreach, assess the needs of individuals who are deaf-blind, identify and supply appropriate equipment, train consumers on the set-up and use of the equipment, and provide ongoing technical

support. DARS has forged a partnership with Perkins and HKNC to build capacity in Texas for the distribution of the technology at the state level.

In addition, people who are deaf-blind face vision and hearing challenges in all aspects of everyday life. Support Service Providers (SSPs) help people who are deaf-blind participate more fully in society, achieve a greater level of independence, and avoid the need for institutionalization, by:

- Relaying visual and environmental information,
- Helping with mobility and access to transportation, and
- Facilitating communication.

Because there are no programs currently providing SSP services in Texas, DARS has entered into an agreement with the University of Arkansas to coordinate and conduct a feasibility assessment regarding the provision of SSP services in Texas.

Using Social Media

Engaging social media is vital to maximizing outreach to consumers and distributing information of interest to the public. DARS is committed to developing a social media presence. The agency already has a YouTube channel and is pursuing the creation of an agency-wide Facebook page. The Facebook page will contain updates about DARS programs, links to stakeholder events, articles written for the Disability History and Awareness campaign, and links to videos on the YouTube site. Initially, social media sites in which DARS participates will be used only as one-way communication outreach vehicles, not a two-way communication method with consumers and stakeholders.

DARS is developing a social media policy that will adhere to guidance drafted in a social media policy for the HHS System and a statewide policy being developed by the Texas Department of Information Resources.

Exploring the Outsourcing of Non-Core Business Functions

Contracting for certain services and additional supports creates opportunities for VR counselors and Rehabilitation Service Technicians to spend less time on non-core services and improve efficiency and the rehabilitation rate. Non-core services are those services not required by regulations to be provided by counselors or staff in direct support of counselor functions, but nonetheless are deemed important to service effectiveness, consumer retention, and improved successful closure rates. These non-core services could include billing support, medical services, profile development, and case management. Initial results of an outsourcing pilot contract in the North Austin Field Office are positive.

Streamlining Contract Management

DARS participates in the HHS System Contract Council, described in this Strategic Plan's *Section 4.5.3, Health and Human Services System Contract Council*. The council works to improve contract management across the HHS System, streamlining and standardizing where appropriate. DARS facilitates development of policies and procedures to help implement the council's Improvement Plan, communicating with and seeking input from agency stakeholders, as appropriate.

- DARS will conduct an internal assessment of contract procurement, enrollment, and renewal processes to identify areas for improvement and standardization.
- Once an interagency contract template is developed and approved by the council, DARS will coordinate with internal agency stakeholders to obtain final approval and develop internal policy and procedures for implementation.
- Once the Enterprise Electronic Signature policy is finalized and approved, DARS will coordinate with internal agency stakeholders to obtain final approval and develop internal policy and procedures for implementation.

7.5.2 Maintaining and Developing the Workforce

Center for Learning Management

The Center for Learning Management (CLM) within DARS develops, delivers, and supports program skills and professional development training for DARS employees. In FY 2012 and FY 2013, CLM is working with DRS to redesign training for new VR counselors and VR support staff. The project is 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.

A complement of deliverables is expected.

- A new course designed specifically for VR support staff.
- Three significantly revised and updated courses for VR counselors.
- A Quick Start Guide for new employees and a companion Quick Start Guide for managers, to develop an individual training plan for the employee, including a checklist of on-the-job training that must occur before the new employee attends the first class.
- Online modules and other e-learning solutions, in the second part of the project, to support ongoing counselor training and development, including the opportunity for specialization.

Strategic Staffing

As VR counselors take a more direct role in working with business, it is important to examine staff roles across the system and adjust as necessary to capitalize on the talents and strengths of staff. Traditional models for service delivery have historically tied staff utilization to a structure that prescribes staff positions per population and administrative support staff per VR counselors and manager units. Staffing decisions have been made in response to historical infrastructure. Unfortunately, that model does not allow for management flexibility to evolving demand by businesses or innovation in customizing approaches to the needs of individuals with disabilities. Implementing strategic staffing should allow DARS the opportunity to identify critical talent needs, systems supports, and key variables to develop best practices.

Division for Blind Services Workforce Planning

A significant percentage of the DBS management workforce is currently or will soon be eligible for retirement. DBS continues workforce planning efforts to:

- Maintain awareness of current and future demands for the human resources talent necessary to provide excellent services, and
- Ensure less experienced staff members are encouraged to develop leadership and management skills.

Alternative Training Methodologies for Blind Services Staff

DBS blindness training for staff has traditionally involved employees traveling to Austin to participate. This traditional method can involve a significant amount of staff time and travel expenses for the agency. DBS provides and will continue to explore opportunities for offering training online. DBS is also exploring videoconferencing. This would reduce travel costs and would allow staff more time to focus on providing services for consumers. DBS will evaluate trainings on a case-by-case basis to determine the most effective delivery method.

Shortage of Orientation and Mobility Specialists

Availability and timeliness of Orientation and Mobility (O&M) services for consumers is dependent on availability of O&M instructors, and counselor and case manager allotment of available monies for consumer services. The state continues to experience a critical shortage of O&M instructors in key areas, such as College Station. There are approximately 85 contracts for O&M services; some contracts have multiple providers working for them, and most contractors are part-time. The expertise of these providers varies, as does their willingness to provide O&M services according to DBS regulations and guidelines. The state is also experiencing increased demand statewide for bilingual English-Spanish O&M instructors. DBS will continue to recruit O&M service providers.

Independent Living Services Wait List

The ILS-general program has had ten staff positions dedicated to serving the IL caseload since 1984. This structure was established to partner and collaborate with the ten original CILs that received funding from DARS to serve consumers needing services unavailable from CILs. Since that time, five new CILs have been established to provide services in areas that were underserved, and they receive funding from DARS. To serve the new areas, the existing IL counselors travel extensively to accommodate ILS consumers in the new CILs catchment areas.

DRS is working with each of the existing ILS caseloads to streamline serving consumers and is working with the Texas Association of Centers for Independent Living (TARCIL) to develop and coordinate cross training. DRS is also reviewing current policies and procedures to provide enhanced guidance on ways to move consumers through the process quicker and more efficiently. The goal is to reduce the ILS waiting list by 40 percent.

Disability Determination Services Workforce

The SSA and DARS DDS have worked diligently to reduce workforce losses. Because it generally takes from two to three years for a specialist to become fully proficient in the job, and in light of SSA's extended hiring freeze, efforts to retain Disability Specialists are critical.

SSA, with the assistance of DDS, led a nationwide project to identify recruitment and retention efforts and concerns within the state DDSs. This workgroup identified and prioritized more than 140 issues and developed recommendations to SSA for addressing the issue of recruitment and retention. DARS DDS will continue to partner with SSA to implement retention efforts and recruit and train proficient staff.

Survey of Employee Engagement

The Survey of Employee Engagement (SEE) is administered every two years by the University of Texas at Austin Center for 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 ultimately delivered to consumers and clients. The data provide management insight into not only employees' perceptions of the effectiveness of their own organization, but also about employees' satisfaction with their employer. DARS executive management will analyze the data and evaluate the information to determine whether any issues identified should be action items to support the initiatives of the agency. Results of the 2012 SEE may be found in Appendix F.

7.5.3 Addressing Infrastructure Needs

Infrastructure Development Refresh

The Infrastructure and Development Platform Refresh Information Resources capital project supports the replacement and upgrade of hardware, mobile computing products, and software. Refreshing, replacing, and upgrading miscellaneous hardware and software is essential to the continued support of DARS and its programs. This includes adaptive software necessary for our staff with disabilities to thrive in their positions. As DARS strives to keep pace with the changing marketplace and move to a mobile business model, Information Resources is researching additional computer applications and devices. And, because today's business use the latest technologies to organize, plan, and achieve success, it is critical that consumers are able to use these same devices to fully participate, engage, and compete in a competitive job market. DARS is working with its program areas to pilot the purchase of mobile applications and hardware. The results of the pilot will determine future policy and business changes.

Data Security Efforts

DARS is committed to protecting the personal information of employees and consumers, including information that can be used to trace an individual's identity and individually identifiable health information. As part of this commitment to keeping such information safe and secure, the agency initiated a Data Security Awareness Project (DSAP). In addition to planning ways to increase employee awareness, the DSAP will update language in DARS contracts and purchase orders, as well as the agency's Contract Processes and Procedures Manual and Business Procedures Manual. In addition, an online course for agency managers will be developed. These specific efforts are expected to be completed by the fall of 2012. However, DARS efforts to increase awareness among all DARS employees and contract workers regarding procedures for proper handling of confidential data and reporting possible breaches in data security are ongoing and considered critical to support the agency's mission.

Facilities Maintenance

Unique to DARS is the maintenance of the Criss Cole Rehabilitation Center. With the age of the facility, there are numerous maintenance issues and increasing needs for more efficiency in space utilization. DARS continues to improve work areas to increase energy efficiency, eliminate safety hazards, and provide increased security. Additionally, the DARS DDS lease is scheduled to expire in 2015. DARS will begin extensive discussions with the Social Security Administration (SSA) and the Texas Facilities Commission (TFC) to ensure new lease terms include all necessary security enhancements to comply with SSA guidelines for DDS occupants.

RehabWorks

DARS has been in the process of developing a single, web-based consumer case management system that meets the business requirements of both DRS and DBS. This system will replace the existing case management applications developed under the legacy Texas Rehabilitation Commission (RehabSys) and legacy Texas Commission for the Blind (TWorks). Using a single system enhances consistency among programs because program changes and modifications will now be applied to only one application, rather than the prior multiple applications. The application will be rolled out to all users in 2012 and 2013.

Disability Case Processing System

For over the past four years, DARS DDS and administrators representing each region, along with SSA executive staff representing the federal case processing partners, have been working together to create a common case processing system for all partners engaged in adjudicating disability decisions. This new system will use a streamlined, common case-processing environment to improve efficiency and accuracy, while preserving excellent customer service. All 54 DDS offices will use the system, which will easily transfer information to and from field offices and other SSA units.

Customers and stakeholders are taking part in designing the new processing system to ensure accurate decisions, timely and cost-effective case processing, optimum worker productivity, and improved employee job satisfaction.

SSA awarded the contract for the new system at the end of 2010 and began onboarding activities with contracted vendor. Critical foundational work started in 2011, with the identification of four beta states, including Texas. Currently, beta-testing and pilots are ongoing in the four states.

7.5.4 Improving Data Quality and Use

The availability of and access to information is vital to agency leadership, consumers, stakeholders, media, the Legislature, and other interested parties. There is a constant need for timely and reliable data to meet ad hoc requests and to support publication of required reports. DARS has a centralized data analysis and statistical reporting unit called Program Reporting and Analysis (PRA). This unit houses the technical expertise required to ensure that data analyses and reports accurately reflect program operations. The unit is the point of contact for consumer statistics reported externally. PRA has worked extensively with DARS Information Resources regarding the implementation of a new data system (RehabWorks) that will serve both DRS and DBS. The implementation of one system improves the data analysis capabilities of the agency as both DRS and DBS will now have common field names and common data warehouse locations.

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

Chapter 8

Department of Family and Protective Services External/Internal Assessment

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 11,000 DFPS employees strive to protect children, adults who have disabilities, and adults who are 65 years old or 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 adults age 65 years or older and adults 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; adults who are elderly, or adults with disabilities; clients served by the Department of State Health Services (DSHS) in State Mental Health Hospitals (SMHs) or the Department of Aging and Disability Services (DADS) in State Supported Living Centers (SSLCs); and children in licensed child-care facilities or treatment centers.
- **Prevention and Early Intervention (PEI)**—PEI manages and contracts with community-based programs to prevent abuse, neglect, delinquency, and truancy of Texas children. PEI programs are administered through contracts with local community agencies or organizations.

The remainder of this chapter is arranged as follows:

- Mission,
- External Assessment,
- Current Activities, and
- Internal Assessment.

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 Assessment

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.
- Ensure 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, older adults, and individuals 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 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: Ensure 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, cost-effective, and customer-friendly.

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

- Improve access to effective behavioral health, prevention, and treatment services.
- Ensure programs and initiatives recognize and address health disparities and disproportionality to improve outcomes across all programs.

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

- Improve detection of potential risk to vulnerable children and adults in the community and in state facilities and ensure that appropriate services are offered and provided when abuse, neglect, or exploitation occurs.
- Work with local law enforcement to support investigations and prosecutions of people suspected of criminal abuse, neglect, or exploitation.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Work closely with faith- and community-based organizations to assist people in applying for nutrition, medical, and monetary assistance, and other service needs.
- Engage communities in developing service delivery systems, programs, and policies.

Discussion

When a child is at risk at home, 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 children with 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; and

- Providing permanent placements for 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, a foster family, an emergency shelter, or a foster care facility. CPS and caregivers are required to arrange all educational, 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 medical and behavioral health services. CPS may conduct 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 a 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 the court approves another permanent living arrangement for the children.

CPS engages with community partners to help develop and implement 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 volunteer opportunities within 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

Enhanced 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.

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. 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 started initiating permanency roundtables. The roundtables will be rolled out over time in the various regions. CPS is starting in Region 6 and the plan is to expand into Regions 8 and 10 in the Fall of 2012 and into other regions thereafter.

The Texas model for PRTs will be an internal team consisting 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.

Implement 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, child protective services best practices have developed the concept of trauma-informed care, so all people who serve a child in care are informed about the trauma and about the conditions and needs that the trauma may cause.

DFPS formed its Trauma-Informed Practice Workgroup (TIPW) in October 2011 as part of the Trauma-Informed Care Initiative. The goal of this initiative is to develop and implement a comprehensive, consolidated approach to trauma-informed care that maximizes agency resources and improves outcomes for the children and families serviced by CPS.

A trauma-informed child- and family-serving system is one in which all parties involved 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 TIPW 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 begin later in the statewide strategic planning period of 2013-17. Workgroups comprised

of internal and external stakeholders will begin meeting 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 abuse and neglect has on children, and decrease the traumatic experiences for children and their families, the workgroup will propose recommendations to DFPS regarding continued integration of trauma-informed practices within CPS. The TIPW will also provide oversight of approved implementation strategies. DFPS expects the transition to a full trauma-informed system of care to continue during the 2013-17 planning period.

Continued Implementation of Fostering Connections

DFPS' implementation of the Permanency Care Assistance (PCA) Program in 2011, also known as Fostering Connections, enables additional permanent placement options for children in the managing conservatorship of CPS. The goal is to have these children exit care to a permanent home with relatives. The program includes verifying relatives as foster parents, placing the child with them for six months, and then having the relative caregivers assume Permanent Managing Conservatorship (PMC) of the child. The relatives then are eligible to receive PCA funding until the child reaches adulthood. Funding for the PCA became available in October 2010. As of February 2012, 415 children had been transferred from DFPS' legal responsibility into the PMC of families through the support of PCA benefits. Over time, this program will assist in reducing the numbers of children in DFPS conservatorship and create permanent homes for children with their own family.

Reducing Disproportionality of Outcomes for Children

African-American and Native American children and their families are disproportionately represented in the CPS foster care system, not only in Texas but nationally. For example, in Texas, in fiscal year (FY) 2011, African-American children made up 12.1 percent of the child population; by contrast, they were 26.2 percent of all children removed from their homes, and 36.8 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; and
- 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 (HHSC's) Center for Elimination of Disproportionality and Disparities. During this strategic planning cycle, DFPS will move forward with a more in-depth examination of disparities in the CPS system for Hispanic children and their families.

8.3.2 Implementation of Foster Care Redesign

Strategic Priority: Ensure 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, cost-effective, and customer-friendly.

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

- Improve access to effective behavioral health, prevention, and treatment services.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Work closely with faith- and community-based organizations to assist people in applying for nutrition, medical, and monetary assistance, and other service needs.
- Engage communities in developing service delivery systems, programs, and policies.

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 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.

The 82nd Legislature, Regular Session, 2011, enacted Senate Bill (S.B.) 218 that directed DFPS to implement the new foster care model. DFPS is implementing the provisions of S.B. 218, and in this planning cycle DFPS anticipates awarding

contracts for two locations, one metropolitan area and one non-metropolitan area. Each of the two contractors will have up to six months to dedicate to start-up activities prior to the first referral of a child needing placement. Evaluation of the Foster Care Redesign will include individual interviews and focus groups, pre- and post surveys on collaboration, and a process evaluation.

8.3.3 Improve and Effectively Target 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 function independently.

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

- Ensure the safety and well-being of Texans in state-regulated, operated, and contracted facilities, as well as those served in their homes.
- Improve detection of potential risk to vulnerable children and adults in the community and in state facilities and ensure that appropriate services are offered and provided when abuse, neglect, or exploitation occurs.
- Work with local law enforcement to support investigations and prosecutions of people suspected of criminal abuse, neglect, or exploitation.

Strategic Priority: Encourage partnerships and community involvement.

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

Discussion

APS is often the only available option to help alleviate or prevent further maltreatment of adults who are elderly or 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 (persons born between 1946 and 1964) will generate a 200 percent increase in the number of persons over

age 65 between 2010 and 2040. This sharp increase in the population over age 65 will result in a significant rise 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 elderly 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 has risen by almost 28 percent between 2008 and 2011. As the number of clients eligible for APS increases, 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, and dementia, many of whom also live in extreme 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.

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 persons over age 65 and adults with disabilities to repeatedly require short-term, emergency assistance from APS. The percentage of clients referred twice within the same year grew from 13 percent in 2008 to 16 percent in 2011.

Facility Program Changes

APS Facility Investigations provide objective, unbiased investigation reports on allegations to state-operated and private providers of services for persons with intellectual disabilities and 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 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 policy and practice with DADS, DSHS, and Disability Rights Texas. Recent efforts have included: expanding referrals to the EMR to include employees of SMHHs and SSLCs; making investigations more efficient by taking electronic witness statements; and implementing the requirement that investigations in SSLCs comply with the Settlement Agreement with the United

States (U.S.) Department of Justice (DOJ) which focused on protecting residents of SSLCs.

One of the observations from the SSLC Settlement Agreement is that current APS policy and practice is not consistent across all provider settings. For example, all investigations in SSLCs must be completed in 10 days, while investigations in other settings can be completed in 14 or 21 days. APS is in the process of examining, with both internal and external stakeholders, whether uniformity in its policy and practice across all settings would result in better investigations.

Planned Actions

Improving and Targeting In-Home Program Services

The APS In-Home program investigates reports of abuse, neglect, and exploitation of adults who are elderly (65 and older), or have disabilities, and provides or arranges for protective services as needed. APS received 108,580 intakes in 2011, up almost 30 percent from 83,605 in 2008. Due to this rapid increase in intakes, the APS In-Home program is closely examining whom it serves and how it serves them.

Texas does not currently make a distinction, in investigation process and findings, between cases with alleged perpetrators and self-neglect cases. In each case, APS completes an investigation, reaches a finding, and conducts an assessment of client strengths and needs. APS is examining current and alternative casework practice models to determine if a differentiated response (including type of assessment and level of services provided), based on the type of allegation and the level of risk, will better protect clients. APS is examining new casework practice models that include safety assessment to determine the need for emergency services, risk 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. APS expects its findings to result in the implementation of tools that will complement or replace elements of the current Client Assessment and Risk Evaluation tool to make client risk assessment more objective, reliable, and simple. It will also aid the caseworker in making consistent and accurate decisions on client need, promote client safety, and result in the best use of agency resources.

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 currently working 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. APS is also reviewing ways to streamline cases in which an expedited investigation would prove most efficient. These changes will ultimately result in rule changes to the definitions of abuse, neglect, and exploitation, will raise the standard of conduct for paid caregivers, and will better focus on individuals most in need of APS services.

By targeting and improving APS In-Home investigations and services, caseworkers will be able to assist clients more effectively, while making the most efficient use of limited resources. Making these changes will also allow APS supervisors the time they need to train and develop their caseworkers. Collectively, these changes will result in improved outcomes for APS clients.

Improving APS Facility Investigations

A top priority for FY 2012 is to determine ways to more rapidly investigate and report allegations of abuse, neglect, and exploitation in facility settings. APS will be working with Facility Investigations staff, providers, and other stakeholders to collect and evaluate potential ideas for improvement. APS will then use the results of this process analysis to make the programmatic changes necessary to protect APS clients better during this planning cycle.

Senate Concurrent Resolution 77, 81st Legislature, Regular Session, 2009, gave legislative approval to the system-wide settlement agreement between the State of Texas and the DOJ relating to the DOJ's investigation of the 13 SSLCs. That settlement called for several changes in the timeframes, documentation, and review of APS Facility investigations in SSLCs and in the portion of the Rio Grande State Center that serves individuals with intellectual disabilities. APS has made the mandated changes to comply with the Settlement Agreement, and it continues to discuss potential issues with the DOJ to ensure DFPS compliance on all settlement requirements at all SSLCs.

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 to vulnerable children and adults in the community and in state facilities and ensure that appropriate services are offered and provided when abuse, neglect, or exploitation occurs.

Strategic Priority: Ensure 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, cost-effective, and customer-friendly.
- Recruit high-quality employees.
- Use technology to maximize work efficiency and eliminate costly maintenance and repair on unneeded and 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 SWI. SWI takes reports on abuse, neglect, and exploitation of children, persons age 65 years or older, or adults 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 must routinely be maintained and upgraded 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 for SWI average hold time for the 2012-13 biennium is 8.7 minutes (+/-5%).

Planned Actions

Enhanced Continuity of Operations

In October 2011 SWI completed implementing the use of Voice over Internet Protocol phones loaded on laptops, to enable SWI staff to work offsite and take calls during business continuity situations, such as weather-related events, disaster recovery events, or social distancing occurrences. This new system is implemented, but limited by the number of available laptops and required terminal number phone lines. SWI will continue to pursue additional laptops and terminal number phone lines to enhance continuity of operations and expand telework options for SWI staff.

Provide Ongoing System Maintenance

Maintaining and enhancing SWI's capacity to handle the increased number of callers and increased demand on its equipment continues to be a DFPS challenge. The ACD system may need to be expanded along with expansion of the call recording system for quality assurance and documentation purposes. More hardware (e.g., laptops and phone lines) may need to be added to maintain the current functionality and 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 environment that supports accountability and innovation.

Strategic Priority: Encourage partnerships and community involvement.

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

Strategic Priority: Ensure 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, cost-effective, and customer-friendly.

Discussion

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 and often differing views regarding what constitutes appropriate care in child care operations and the degree of robust regulation needed to enhance outcomes for children. CCL is continually challenged to balance regulatory responsibility with the availability and affordability of care. Challenges exist for CCL to provide child care providers with more automated options related to licensing requirements, such as an ability to pay licensing and background check fees online.

Unregulated care consists of persons providing child care services illegally, operating without the required permit, training, background checks, and ongoing regulatory oversight to 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. Therefore, recommendations for changes to minimum standards and regulatory requirements must be weighed against the potential impact on child care operations, the affordability and availability of care, available staffing resources, and the risk to children placed in unregulated care.

The expected growth of the state's population presents a continuing challenge to CCL to support and improve capacity and quality, while maintaining availability and affordability of child day care and residential child care services. It is vital that CCL ensures stakeholder participation in the process of identifying licensing outcomes for children in out-of-home care and use these as guiding principles when proposing changes to minimum standards.

Minimum Standards of Care

CCL is statutorily mandated to review all rules and standards for child care operations every six years, and 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.

A comprehensive review for child-care standards was conducted from 2009 to 2010, and the last comprehensive review for 24-hour residential care standards was completed in 2007. In 2009 and 2010, based on a CCL-identified need to ensure that the 24-hour residential care standards were having the intended outcome for children in care, DFPS conducted an evaluation or modified review of the 24-hour residential care standards.

Technology and System Improvements

Although CCL offers many technologically advanced web-based features which help educate consumers and support permit holders and applicants, CCL is challenged with technological limitations regarding the collection of statutorily required licensing fees. The current system's design is largely focused on the electronic case management of regulatory activities such as recording and storing outcomes of monitoring inspections or investigations of child abuse and neglect in child care operations. The system was not designed as a financial database and does not currently provide for submission of online payments, thus making the fee submission and tracking process cumbersome for permit holders as well as agency staff. CCL is exploring ways in which the fee collection process could be improved to enhance support for child care operations in Texas.

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 2013-17, with stakeholder involvement starting in the next two years. CCL also plans to explore changes to the inspection frequency, currently specified in statute, of well-performing operations, which would allow for the redirection of some of its staffing resources to better target those operating illegally. A statutory change in inspection frequency would likely require changes to related minimum standards in order to implement a differential monitoring approach. Changes in residential child care minimum standards may also be needed to support CPS efforts for redesigning the foster care system in Texas. CCL is currently assessing which standards, if any, would require changes to support a provider continuum of care model in the redesigned system.

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, advisory councils, staff, and legislative leadership in providing input and comment. In the course of reviewing all standards as required by statute, and in conjunction with stakeholders, CCL will be assessing standards related to the social and emotional development of children, promoting children's healthy development, and responding to mental health or behavioral concerns of children in care. CCL has also begun taking steps to train its staff on trauma-informed care and practice in relation to its regulatory role and group care settings. CCL will continue in this effort and will evaluate the need to amend standards regarding provider training during this review process.

CCL will post proposed changes to minimum standards on its website and will 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 year-round 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.

The Committee on Licensing Standards, statutorily mandated in 2009, makes recommendations to the Legislature and DFPS for policy and statutory changes relating to licensing standards and facility inspections. This committee reviews all proposed changes to minimum standards and gives feedback to CCL on the proposed changes, modification, or deletions. The committee also develops a statutorily-mandated annual report to Legislative leadership and to the DFPS Council with recommendations for legislative and policy changes related to child-care in Texas. The committee will continue to produce the report in this planning cycle, and each report will address the Committee's views on proposed or adopted changes to minimum standards that occurred in the previous 12 months.

Improve Licensing Fee Collection

CCL has met with stakeholders and licensing staff at varying levels to better pinpoint the process and technological weaknesses involved in the collection of licensing fees. CCL will explore process changes that can be made to improve the current structure of collecting and recording fees, such as improving the written notice given to providers about fees coming due and potential consequences for non-payment of the required fees. CCL will also fully assess the degree to which funding would be needed either to improve the current fee module in the agency's databases or to implement an online fee payment system.

8.3.6 Enhancing Client Safety by Ensuring Due Process Rights

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

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

Discussion

To protect vulnerable clients, there is increasing emphasis on sharing information about perpetrators of abuse, neglect, or exploitation with private employers, other governmental agencies, and entities in other states. However, when sharing information deprives the perpetrator of a protected liberty or property interest, such as employment, there are constitutional requirements to offer a due process hearing.

Hearings Currently Offered

DFPS currently offers a hearing following an administrative review for:

- Persons found by CCL to have committed abuse or neglect in a child-care facility, and
- Employees of long-term care facilities who are found by APS to be perpetrators and who are subject to listing on the EMR.

However, most perpetrators of abuse/neglect in the CPS program and in the APS in-home program do not pose a threat to vulnerable persons outside the home where the abuse/neglect occurred. Significant resources would be required to provide a due process hearing to all such perpetrators, so DFPS does not offer a hearing unless and until the department must share the perpetrator's information outside the department. Ordinarily this information is only shared by DFPS for the purpose of mandatory employment background checks for people in the child-care industry.

Because most abuse/neglect findings cannot be released to a child-care facility or the EMR until a due process hearing has been conducted and the findings have been upheld, it is essential that due process hearings occur in a timely manner. Children and vulnerable adults are left unprotected when DFPS is unable to share perpetrator information in a timely manner, because the perpetrator may continue to have access to vulnerable clients served by the child-care and long-term care industries. Moreover, both DFPS and the designated perpetrator are at a disadvantage in presenting their case when the hearing does not take place until many years after the finding is made, when memories have faded, witnesses cannot be located, and evidence is lost.

Recent Developments

Additional funding was appropriated to reduce the backlog of due process hearings in the 2012-13 biennium. DFPS is on track to reduce the backlog by 42 percent.

At the start of FY 2012, there were 2,070 pending CCL-related cases, roughly half of which had been awaiting a hearing for more than a year, and one quarter of which had been waiting for a hearing for more than two years.

Assuming that DFPS reduces the backlog by the projected 42 percent, a backlog of more than 1,000 cases still will remain at the end of the current biennium. This continued backlog poses safety concerns, as delays in providing due process to perpetrators means a delay in removing them from settings in which the perpetrators have access to children and vulnerable adults.

In addition, there has been significant interest in expanding the use of CPS findings to bar employment in other work settings, including public schools. There is also a federal mandate to create a National Child Abuse Registry to promote releases of perpetrator status across state lines, although the timing of implementation for such a registry is likely still many years away, and it is not yet known whether the national registry will be used for employment screenings.

Planned Actions

With the additional funding appropriated to DFPS by the 82nd Legislature, DFPS will continue to address the backlog until it is eliminated. Once the backlog has been eliminated, DFPS will determine whether it is possible to begin to offer "up front" due process, either within existing resources, or contingent upon additional resources in a future biennium.

8.4 Current Activities

8.4.1 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 older adults or adults with disabilities; clients served by the Department of State Health Services (DSHS) in State Mental Health Hospitals (SMHHs) or the Department of Aging and Disability Services (DADS) in State Supported Living Centers (SSLCs); and children in licensed child-care facilities or 24-hour care.

Service 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 64,634 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 caller's need. SWI generates Law Enforcement Notifications and routes them to the correct law enforcement jurisdiction for all abuse, neglect, and exploitation reports involving children.

SWI assesses 52.5 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, 40 percent are assessed as information and referral (I&R) calls related to DFPS work (such as additional information about an open case without an allegation) and 7.7 percent are I&R calls not related to DFPS work (such as providing the number for the Medicare hotline). Of the calls assessed as intakes, 66.8 percent go to CPS, 31.4 percent go to APS, and 2 percent go to CCL.

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.

8.4.2 DFPS Goal 2: Child Protective Services

Target Population

The 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, 6.6 million children live in Texas.

In FY 2011, the CPS program conducted 175,421 investigations of abuse and/or neglect. CPS confirmed abuse and/or neglect in 39,263, or 22 percent, of reported cases. The most commonly confirmed types of abuse/neglect were physical abuse, physical neglect, and sexual abuse. The 39,263 confirmed cases of abuse or neglect involved 65,948 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 65,000 children in confirmed cases of abuse or neglect during FY 2011.

**Table 8.1
 Characteristics of Confirmed Victims of Child Abuse, Fiscal Year 2011**

Sex	Anglo	African American	Hispanic	Native American	Asian	All Other Population Groups Combined
Female	10,190	6,791	15,742	74	149	1,132
Male	9,946	6,654	13,963	69	145	953

Table 8.1: DFPS Databook, FY 2011.

In some cases, children may require substitute care placements outside of their homes. At the end of 2011, DFPS had legal conservatorship for 27,875 children in substitute care. Table 8.2 details the types of placements in which these children were residing.

Table 8.2
Children in Substitute Care Placements, by Living Arrangement,
at the End of Fiscal Year 2011

Type of Living Arrangement ¹	Number of Children	Percentage of Total
Contracted Foster Homes	11,095	40.9%
Kinship Care	9,912	36.5%
DFPS Foster Homes	1,974	7.3%
Residential Treatment Centers	1,527	5.6%
Basic Child care	697	2.6%
Other Substitute Care	574	2.1%
Emergency Shelters	471	1.7%
Private Adoptive Homes	351	1.3%
Other Foster Care	265	1.0%
DFPS Adoptive Homes	260	1.0%
Independent Living	13	0.05%
Total	27,139	100.0%

Table 8.2: DFPS Data Warehouse, December 2011.

Of the children residing in foster care at the end of FY 2011, 54.2 percent were boys and 45.8 percent were girls. Age groups were represented as follows:

- 22.1 percent were two years of age or younger,
- 16.9 percent were from 3 to 5 years of age,
- 17.2 percent were from 6 to 9 years of age,
- 17.3 percent were from 10 to 13 years of age,
- 23.1 percent were from 14 to 17 years of age, and
- 3.4 percent were from 18 to 20 years of age.

Ethnic groups of the children in foster care were represented as follows:

- 38.1 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 2011.

- 30.3 percent African American,
- 29.4 percent Anglo,
- 0.3 percent Native American,
- 0.3 percent Asian, and
- 1.7 percent all other population groups combined.

The population of children in DFPS conservatorship has increased over the past three years. This coincided with an increase in the number of investigations over the same years. Various factors may have contributed to this situation, among them the weakened economy and an increase in the child population in Texas.

Service 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)**—Services 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.

8.4.3 DFPS Goal 3: Prevention Programs

Target Population

Prevention and Early Intervention (PEI) target populations mirror the CPS program populations; however, contracted prevention services target specific regions of the state and, in some cases, specified client groups. Prevention services contracts are discussed in the following Service Description section.

Service Description

The PEI Division manages the statewide prevention services contracts described below. The division focuses on contracting for quality services and is charged with identifying and measuring meaningful outcomes for contracted services.

- **Community Youth Development (CYD)**—The CYD program contracts with community-based organizations to develop juvenile delinquency prevention programs in ZIP codes with high juvenile crime rates. Approaches used by communities to prevent delinquency have included mentoring, youth employment programs, career preparation, and recreational activities. Communities prioritize and fund specific prevention services according to local needs. CYD services are available in 15 targeted Texas ZIP codes. In FY 2011, 19,731 youth were served through CYD.
- **Services to At-Risk Youth (STAR)**—The STAR program contracts with community agencies to offer family crisis intervention counseling, short-term emergency respite care, and individual and family counseling services to all 254 counties. Youth through the age of 17 and their families are eligible if there is conflict at home, if there is truancy or delinquency, or if a youth runs away from home. Each STAR contractor also provides universal child abuse prevention services, ranging from local media campaigns to informational brochures and parenting classes. In FY 2011, 30,168 youth were served through STAR.
- **Texas Families: Together and Safe (TFTS)**—TFTS funds evidence-based, community-based programs designed to alleviate stress and promote parental competencies and behaviors that increase the ability of families to become self-sufficient and successfully nurture their children. The goals of TFTS are to:
 - improve and enhance access to family support services;
 - increase the efficiency and effectiveness of community-based family support services;
 - enable children to remain in their own homes by providing preventative services; and
 - increase collaboration among local programs, government agencies, and families.

In FY 2011, 2,110 families in targeted areas of the state were served by TFTS.

- **Community-Based Child Abuse Prevention (CBCAP)**—The program seeks to increase community awareness of existing prevention services, strengthen community and parental involvement in child abuse prevention efforts, and encourage families to engage in services that are already available. CBCAP funds a variety of contracts, in targeted areas of the state, with community based organizations to provide child abuse and neglect prevention services. These include the Relief Nursery, the Fatherhood and Leadership for Effective Parenting, the Family Support and the Rural Family Support programs, as well as various special initiatives and public awareness campaigns. In FY 2011, 461 families were served through CBCAP contracts.
- **Family Strengthening**—A variety of Family Strengthening home visitation services, available statewide, have been evaluated and proven to effectively

increase family protective factors. These services are designed to increase the resiliency of families and prevent child abuse and neglect. Programs must also foster strong community collaboration to provide a continuum of family services. In FY 2011, 938 families were served in the Family Strengthening Program.

- **Youth Resiliency**—Youth Resiliency Programs provide life skills shown to increase protective factors for youth and prevent juvenile delinquency. These programs must foster strong community collaboration to provide a continuum of services for participating youth. In FY 2011, 1,066 youth received services through the Youth Resiliency program.
- **Community Based Family Services**—This program provides community and evidence-based services to families who were investigated by CPS, but whose allegations were unsubstantiated. Services include home visitation, case management, and additional social services to provide a safe and stable home environment. In FY 2011, 280 families received services through the Community Based Family Services program.
- **Tertiary Child Abuse Prevention**—Community-based, volunteer-driven prevention, intervention, and aftercare services are provided for children who are or have been, or who are at risk of being, abused and/or neglected. The goals of the program include reducing child maltreatment and the number of families re-entering the Child Protective Services system. Additional goals are to improve the quality and availability of aftercare services for abused children and to enhance a statewide network of tertiary child abuse prevention programs. In FY 2011, 44 families received services through the Tertiary Child Abuse Prevention program.
- **Statewide Youth Services Network**—The Statewide Youth Services Network contracts provide community and evidence-based juvenile delinquency prevention programs focused on youth ages 10 through 17, in each DFPS region. In FY 2011, 5,720 clients received mentoring and group skills through the Statewide Youth Services Network funded programs.
- **Texas Youth and Runaway Hotlines**—These hotlines serve exclusively Texas youth and families, by providing both 24-hour crisis intervention and telephone counseling and I&R services. In FY 2011, the hotlines responded to 9,757 calls.

8.4.4 DFPS Goal 4: Adult Protective Services

Target Population

The Adult Protective Services (APS) program serves older Texans and persons with disabilities who are experiencing or who are at risk of abuse, neglect, and/or exploitation. In 2011, there were nearly 2.6 million Texans 65 years or older and almost 2.1 million Texans with a disability who were 18 to 64 years old. APS investigates allegations of abuse, neglect, and/or exploitation for persons in two settings:

- Their own homes, and
- State-operated and/or state contracted facilities for people with mental health issues and/or intellectual disability.

In-Home Investigations

Of the 58,068 validated victims in In-Home investigations completed in FY 2011, 29,247 (50.3 percent) were adults with a disability and 28,821 (49.7 percent) were older adults. More than 60 percent of the individuals in validated cases were women. The most common type of maltreatment validated was physical neglect, which was found in 64.9 percent of the cases validated. Ethnic groups of victims in validated cases were represented as follows:

- 50.6 percent Anglo,
- 23.2 percent African American,
- 22.9 percent Hispanic,
- 0.3 percent Native American,
- 0.5 percent Asian, and
- 2.4 percent from all other population groups combined.

The number of completed APS In-Home investigations is projected to increase steadily during the strategic planning period of 2013-17. One major reason for the increase is the growth in the number of "baby boomers" who are turning 65 years of age or older.

Facility Investigations

In the Facility Investigations program, 10,981 investigations led to 1,355 confirmed cases in FY 2011. Neglect was confirmed in 56.9 percent of all confirmed investigations, followed by physical abuse as the second most common type, found in 23.2 percent of confirmed cases. SSLCs were the most common setting for facility investigations, accounting for 39.3 percent of completed investigations.

Service Description

APS operates two programs: In-Home Investigations and Services, and Facility Investigations. In validated In-Home cases, if needed, APS caseworkers provide or arrange for protective services, including referral to other programs, respite care, transportation, counseling, and emergency assistance with food, shelter, and medical care. The In-Home program completed 87,741 In-Home investigations in FY 2011, with 58,068, or 66 percent, investigations resulting in validated allegations of abuse, neglect, and/or exploitation.

The Facility Investigations program investigates reports of abuse, neglect, and exploitation of clients receiving services in state-operated facilities (SMHHs, SSLCs, and Rio Grande State Center), private Intermediate Care Facilities for Persons with

Intellectual Disabilities (ICFs/ID), and state-contracted settings (community centers and certain DADS Services Medicaid waiver programs for persons with intellectual disabilities, such as Home and Community Services (HCS)) that serve adults and children with mental illness or intellectual disabilities. In FY 2011, there were 10,981 completed investigations in facility settings, of which 2,079 were performed in SMHHs, 4,318 in SSLCs, 244 in Rio Grande State Center, 2,685 in HCS settings, 551 in community centers, and 1,104 in ICFs/ID. In FY 2011, completed investigations in facility settings were 10.7 percent higher than in FY 2010, and 12.9 percent higher than in FY 2009.

8.4.5 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 2011, the capacity of regulated child care operations in Texas was 1,073,882 children. The capacity of residential child care providers was 42,776 children.

Service 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 enforcement team conferences 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 to 18 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 is to providers, parents, and others.

The following paragraphs focus on the demand for services within the different facility types.

Day Care Licensing

In FY 2011, approximately 5.2 million children 13 years of age or younger 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 2011, CCL was responsible for regulating 9,519 licensed child care centers, 1,743 licensed child care homes, 6,302 registered family homes, and 7,477 listed homes, for a combined capacity to serve more than one million Texas children. Additionally in FY 2011, CCL issued a combined 5,094 new licenses, registrations, and listings and conducted 48,051 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 2011

Day Care Facilities	Total Number of Facilities	Number of Inspection Visits
Licensed Child Care Centers (includes Child Care Programs, Before/After School Programs, School-Age Programs, and Temporary Shelters)	9,519	33,589
Licensed Child Care Homes	1,743	4,089
Registered Family Homes	6,302	9,036
Listed Family Homes	7,477	1,334
Employer-Based Child Care	4	3
Total	25,045	48,051

Table 8.3: DFPS Databook, FY 2011.

Residential Licensing (24-Hour Care)

The CCL program also licenses and regulates 24-hour residential child care facilities including general residential operations, residential treatment centers, and child-placing agencies. In FY 2011, Texas' residential child care facilities had a combined capacity to serve over 42,000 children. In FY 2011, CCL issued 46 permits for new residential child care facilities and performed 11,553 inspection visits. Table 8.4 lists the total number of licensing inspections conducted in regulated residential child care facilities in FY 2011.

**Table 8.4
 Number of Inspection Visits in Regulated Residential Child Care Facilities,
 Fiscal Year 2011**

Residential Child Care Facilities	Total Number of Facilities	Number of Inspection Visits
General Residential Operations	160	1,515
Residential Treatment Centers	85	1,913
Child Placing Agencies	350	4,929
Child-Placing Agency Foster and Foster Group Homes	7,567	2497
CPS Adoptive, Foster and Foster Group Homes	2,600	651
Independent Foster Homes and Group Homes	4	22
Maternity Homes	8	26
Total	10,774	11,553

Table 8.4: DFPS Databook, FY 2011.

Initiative: Controlling Persons in Child Care Operations

Included in CCL's standards, rules, and applicable law is the concept of the "controlling person," an individual who is held accountable for an adverse event at a child care facility, such that CCL takes adverse action against the organization. State law defines controlling person as "a person who, either alone or in connection with others, has the ability to directly or indirectly influence or direct the management, expenditures, or policies" of a child care operation. (Tex. Hum. Res. Code Section 42.002.) Until September 2011, this concept applied only to 24-hour residential child care facilities, and, as a result of S.B. 1178, 82nd Legislature, Regular Session, 2011, the definition now includes controlling persons of child day care operations. This is a significant change for Texas child day care providers, of which there are many.

As a controlling person, an individual is accountable for and responsible for the safety of children, including compliance with CCL standards and regulations, or lack of compliance that leads to the revocation of a child care permit. If CCL takes adverse action against a child care operation and denies or revokes the permit, then the responsible person is prohibited from being employed or serving as a controlling person, after the person's due process is complete, in any child care operation for a period of five years, even while the permit denial or revocation is pending appeal.

This change in law requires CCL to record and report information and history about this new population of controlling persons. In addition, S.B. 78, 82nd Legislature, Regular Session, 2011, requires HHS agencies to communicate with each other about persons whose actions caused an agency to take adverse action, to prevent such persons from continued contact with or responsibility for at-risk populations.

This initiative began in June 2011. Focus and attention has been given to meeting the highest priority requirements through a manual tracking process, while at the same time exploring the possibility of an automated business process when resources permit.

8.5 Internal Assessment

8.5.1 Continuous Improvement of Business Processes

GoMobile Business Model

By capitalizing on current tools and exploring ways to take advantage of new technological developments, DFPS has constructed a business model, the GoMobile project, to help staff to work more flexibly and efficiently.

DFPS caseworkers are mobile workers, spending 60 to 70 percent of their time with clients 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 change reduces the amount of space needed for offices and thus allows for consolidation and cost savings, while increasing productivity. The project has a phased completion schedule, with most goals being 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.

As this business model is deployed, DFPS information technology staff will work 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 HHS System Contract Council, described in *Section 4.5.3, Health and Human Services System Contract Council*. The council works to improve contract management across the HHS System, streamlining and standardizing where appropriate.

DFPS will undertake multiple activities in support of the council's Improvement Plan efforts and in improving processes within DFPS related to streamlining administrative requirements.

- Active participation by the DFPS Contract Oversight and Support (COS) Director on the Enterprise Standards workgroup meetings and subsequent sharing of information with DFPS agency stakeholders that include DFPS staff and other stakeholders impacted by anticipated changes.
- Adding council-endorsed changes to the DFPS Internal Contract Improvement Workplan and the COS workplan, aligning policies and procedures with Improvement Plan recommendations. These anticipated policies will ultimately allow streamlined processes for contract management staff and contractors.
- Conducting an internal assessment of DFPS contracts to identify contracts that can be renewed at intervals greater than one year, taking into account the risk associated with a longer renewal period and implementing a policy to implement such a change.
- Publishing final anticipated changes to the Interagency Contract and signature policies in the Contract Handbook.

8.5.2 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 the first quarter of FY 2012. The highest turnover in FY 2011 was CPS FBSS workers at 27 percent and CPS Investigators at 32 percent. There are also areas of the state that see higher turnover than others: DFPS Region

7 (Austin), at 23 percent, and Region 11 (Rio Grande Valley) at 23 percent in FY 2011.

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 ways detailed here are designed to identify the best applicant to deliver services and improve both job satisfaction and employee 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 Child Protective Services 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 APS, CPS, and CCL employees 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 S.B. 758, 80th Texas Legislature, Regular Session, 2007, 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, 82nd Texas Legislature, Regular Session, 2011, 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 79th Legislature, Regular Session, 2005.

- **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.

8.5.3 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, and tablet personal computers (tablet PCs), are providing an opportunity for DFPS to transition to a direct delivery workforce that is increasingly mobile. These improvements raise important questions that must be addressed.

Enhanced Use of Mobile Technology and Impact on Office Space Needs

Currently all casework employees are issued tablet PCs which allow them to access the DFPS network to perform their work while in the field. Each employee receives an air card that is used to connect the tablet to the DFPS Network. DFPS is working to enhance the functionality of tablet PCs. A pilot starting in the spring of 2012 will enable Wi-Fi, so that caseworker staff can exchange data wirelessly and securely over a computer network, via a wireless network access point. This pilot will allow caseworkers an additional connectivity option outside of the office—in the employee's home, a courthouse, a library, or other locations. Also planned in the next few years is developing or expanding DFPS offices with wireless connectivity. This will allow workers to connect to a mobile access point within a DFPS office. This will provide workers the needed flexibility to move within an office location without having to be tethered to a specific spot within the building.

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 evolve, there will be a decreased need for DFPS employees to return to the office. In view of this evolution, DFPS will continue to work with HHSC towards a goal of reducing office space.

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 must maintain the confidentiality, integrity, and availability of information resources to accomplish its mission. Information and the infrastructure that houses it 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 HHS 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, one of which is typically a physical token, such as a card, and the other of which is typically something 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 which 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.

DFPS participates with HHSC 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 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.

Chapter 9

Department of State Health Services External/Internal Assessment

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 \$2.9 billion and a workforce of approximately 12,500 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. This mission is accomplished in partnership with numerous academic, research, and health and human services stakeholders within Texas, across the country, and along the United States (U.S.)/Mexico border. Service system partners serve important roles in working collaboratively to address existing and future issues faced by the agency:

- Health and Human Services (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 Assessment,
- Current Activities, and
- Internal Assessment.

9.2 Mission

The mission of DSHS is to improve health and well-being in Texas.

9.3 External Assessment

9.3.1. 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 preparedness and response, including prevention of future threats.
- Emphasize health promotion, primary care, disease prevention, and early intervention in a quality-oriented, cost-effective system of care, improving outcomes for long-term public health and well-being.

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 environment that supports accountability and innovation.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Engage communities in developing service delivery systems, programs, and policies.

Discussion

Texas faces many different emergency situations, ranging from hurricanes, floods, and tornados to disease outbreaks. Public health preparedness is the state of being ready for a natural disaster, major incident, disease outbreak, biological attack, or other public health emergency. In a state the size of Texas, with very large and small communities, planning and response activities require close coordination with federal, state, and local jurisdictions. DSHS is the primary agency for coordinating health and medical preparedness and response activities in Texas. This includes

activities such as medical evacuations and sheltering of medically fragile individuals, and public communications about personal health protection. Preparedness and response activities must address not only public health and medical services, but also chemical, biological, radiological, and nuclear events.

Planned Actions

Public Health Emergency Preparedness and Response

DSHS coordinates a statewide public health preparedness and response program to address the public 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 will monitor the retention and recruitment of epidemiologists to ensure the capacity to conduct epidemiological surveillance is adequate.

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 food-borne, water-borne, respiratory, and vaccine-preventable diseases. Staff works to ensure rapid detection of an outbreak and a coordinated response. DSHS will continue to refine a structured framework within which outbreaks are effectively investigated and brought under control 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 in Texas food-borne disease causes approximately 6 million illnesses, 26,000 hospitalizations, and 400 deaths 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, and loopholes exist in statute that specifically exempt or fail to address significant portions of the “farm to fork” supply chain. Of the portions of the food supply chain that are regulated, there are approximately 24,000 manufacturing and distribution licensees and 96,000 retail foods licensees; 85,000 of the retail firms are licensed and inspected by local health departments. There may be manufacturing, distributing, and/or retail facilities that are not licensed, whether willfully or through ignorance of the law.

When an illness, injury, or outbreak occurs despite best efforts, the agency has response capabilities using federal, state, and local partnerships to respond quickly to the event. The main goal of the response is to 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.

9.3.2. Preventing Chronic Diseases and Infectious Diseases

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

- Emphasize health promotion, primary care, disease prevention, and early intervention in a quality-oriented, cost-effective system of care, improving outcomes for long-term public health and well-being
- Work with partners to develop public health strategies to improve outcomes and to contain health care costs.
- Ensure programs and initiatives recognize and address health disparities and disproportionality to improve outcomes across all programs.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Engage communities in developing service delivery systems, programs, and policies.

Discussion

Chronic Disease

Chronic diseases are generally characterized by multiple risk factors, a long latency period, a prolonged course of illness, non-contagious origin, functional impairment or disability, and low curability. See Chapter 3, Table 3.1 and related text for information relating to the ten leading causes of death in Texas in 2009.

Chronic and infectious diseases impact thousands of Texans each year. Many of these conditions are exacerbated by behavioral risk factors such as tobacco use, obesity, physical inactivity, consumption of alcohol and other drugs, and poor nutrition.

Cardiovascular Disease

Cardiovascular Disease (CVD) and stroke are the number one and number four causes of death in Texas. CVD refers to a group of disorders that affect the heart and blood vessels. Common forms of CVD include heart disease, stroke, and congestive heart failure. Risk factors associated with CVD include hypertension, tobacco use, high cholesterol levels, physical inactivity, poor nutrition, and secondhand tobacco smoke. African Americans had the highest rates of mortality from CVD in 2009, compared with Anglos and Hispanics.

Cancer

Cancer, the second leading cause of death in Texas, represents more than 100 distinct diseases that are characterized by the uncontrolled growth and spread of abnormal cells in the body. In 2012, it is estimated that more than 110,135 Texans will be newly diagnosed with cancer, and about 39,000 will die from the disease. Behaviors contributing to the cancer rate include tobacco use, poor nutrition, physical inactivity, and obesity. African Americans living in Texas have the highest overall rates for new cancer cases and deaths compared to other racial or ethnic groups.

Diabetes

Diabetes can lead to disabling health conditions, including heart disease, stroke, kidney failure, leg and foot amputations, and blindness. One of the risk factors associated with the development of diabetes is obesity, which is increasing in prevalence. Estimates indicate that the total number of Texas diabetes cases will increase by 50 percent in the next 30 years, from 1.8 million in 2010 to almost 2.7 million in 2040. The 2009 mortality rates (per 100,000) for African Americans were more than double that of Anglos.

Behavioral Risk Factors

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—more than the total number killed by acquired immunodeficiency syndrome (AIDS), alcohol, motor vehicle accidents, homicides, illegal drugs, and suicide combined. In Texas, 24,200 adults die annually from smoking-related causes. This equates to one person every 22 minutes. Additionally, for every person who dies from a tobacco-related cause, an additional 20 suffer from tobacco-related diseases.

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 2010, two out of three adult Texans were either overweight or obese, with rates higher among African Americans (73.7 percent) and Hispanics (74.3 percent) than among Anglos (62.9 percent). According to the Behavioral Risk Factor Surveillance System (BRFSS), conducted by the Centers for Disease Control and Prevention (CDC), persons of low socioeconomic status are particularly affected (69.9 percent when annual income is less than \$25,000). The Texas state demographer projects that, if current trends continue at the pace of the last 10 years, then by 2030, 36.7 percent of Texas adults will be obese, 36.4 percent will be overweight, and only 26.9 percent will be at normal weight.

Substance Abuse

According to the 2010 Texas BRFSS, approximately 49.9 percent of Texas adults reported that they had consumed alcohol in the past month; 14.6 percent reported past-month binge drinking; and 4.9 percent reported that they were heavy drinkers. (Note: For men, heavy drinking is typically defined as consuming an average of more than two drinks per day. For women, heavy drinking is typically defined as consuming an average of more than one drink per day.) The percentage of heavy drinkers by race and ethnicity was 5.5 percent for Anglos, 4.9 percent for Hispanics, and 2.8 percent for African Americans. Among the youth population, the 2010 Texas School Survey of Substance Use found that 23.7 percent of Hispanic secondary students reported past-month binge drinking, compared to 19.2 percent of Anglo students and 13 percent of African-American students. The percentage of past-month illicit drug use was 14.8 percent of Hispanic students, 13.1 percent of African-American students, and 11 percent of Anglo students.

Infectious Disease

Bacteria, viruses, or other microorganisms cause infectious diseases. Information regarding human immunodeficiency virus (HIV), tuberculosis (TB), and other

infectious diseases is provided below as are actions that DSHS is taking to combat these problems.

Human Immunodeficiency Virus

From 2004 to 2010, the number of persons living with HIV in Texas increased about 36 percent. At the end of this period, 65,077 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 5 years.

In Texas, in 2010, the rate of persons living with HIV among African Americans (852.4 per 100,000 population) was four times higher than the rate for Anglos and Hispanics (191.2 and 175.4 per 100,000 population, respectively). Also, many subpopulations in the largest metropolitan areas of the state had rates above 1,000 per 100,000 population. African-American men older than 35 years of age were the most affected subpopulation in each metropolitan area.

Tuberculosis

In 2010, there were 1,385 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 58 percent in 2010. In 2010, Texas border counties had a TB rate of 9.9 cases per 100,000 residents, while non-border counties had a rate of 4.9 per 100,000. The total state rate was 6 per 100,000 residents, which exceeds the national rate of 3.6 per 100,000 population.

In Texas, ethnic, racial, and gender disparities are observed among persons likely to be diagnosed with TB. In 2010, the incidence rate among Anglos was 1.8 cases per 100,000 population, while the rate among African Americans and Hispanics was six and four times greater than that of Anglos. Gender disparities also exist among persons likely to develop TB. In 2010, 66 percent of reported cases were among men while only 34 percent of cases were among women.

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 has been able to decrease the incidence of several diseases. For several years, Texas has not had any cases of rubella, congenital rubella syndrome, polio or diphtheria. The incidences of hepatitis A, acute hepatitis B, and varicella (chicken pox) have decreased steadily and are now at historic lows (139 cases of hepatitis A, 394 cases of acute hepatitis B, and 2,760 cases of varicella in 2010). 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 2011, six cases of measles were identified in Texas, all associated with foreign travel or exposure to foreign travelers.

Planned Actions

Tobacco Prevention and Control

The DSHS Tobacco Prevention and Control Program activities are guided by goals and objectives developed through a statewide strategic planning process that included 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.

DSHS will continue to provide program activities at the local level. This will be accomplished through regional tobacco program coordinators and Prevention Resource Center tobacco specialists.

Obesity Prevention

The DSHS Nutrition, Physical Activity, and Obesity Prevention (NPAOP) program supports and promotes projects that focus on CDC six evidence-based target areas for reducing obesity: 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 policies that facilitate healthy choices.

Fiscal year 2012 will be the program's fourth year of a five-year CDC obesity prevention grant. With CDC funds, DSHS NPAOP will continue to support:

- Community projects focusing on evidence-based policy and environmental changes for one or more of the CDC's obesity prevention target areas, mentioned above;
- The Strategic Plan for the Prevention of Obesity in Texas;
- The bi-annual obesity summit for statewide partners;
- 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 225 school- and community-based programs statewide to prevent the use and consequences of alcohol, tobacco, and other drugs (ATOD) among Texas youth and families. These programs provide evidence-based curricula and prevention strategies in over 500 school districts. The primary population served is youth, from birth through age 17, and the secondary population includes the parents and guardians of these youth. In addition to these direct services, there are 11 regional prevention resource centers that provide a clearinghouse of information and resources on the harmful effects of ATOD. 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.

DSHS contracts with state licensed treatment programs and other community providers to deliver services to adolescents (ages 13 through 17) and adults (ages 18 and older). A funding formula determines the amount of funding allocated for each of the 11 HHSC regions in Texas, including the state's behavioral health care contract, NorthSTAR, which serves the Northeast Texas area. Each region provides a continuum of treatment that includes: outreach, screening, assessment, and referral and specialized services for females, pharmacotherapy, and co-occurring disorders.

HIV Prevention and Control

As the number of Texans living with HIV grows, so do the costs of providing treatment and care. 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. Goals for HIV prevention and control are:

- Promoting integration of HIV, STD, 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 STD and HIV diagnosis and treatment delivery that make the most of technology.

TB Prevention and Control

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.
- Develop 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.
- Promoting targeted interventions to populations most at risk for developing TB.

The Texas Center for Infectious Disease (TCID) provides in-patient 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 out-patient 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

Coverage levels for Texas children measured in the National Immunization Survey for 2010 were 70.1 percent, statistically similar to the 2009 survey. Coverage levels for adolescents are increasing as a result of policy changes made in 2009 to require 7th-graders to be vaccinated against diphtheria/tetanus/pertussis meningococcal, and varicella. Coverage levels for adults continue to be a challenge. Unlike childhood vaccines that are recommended at specific intervals and ages, the recommendations and licensure for adult vaccines vary over the lifespan. DSHS will continue to support efforts to increase adult immunization rates.

To achieve and sustain recent successes, DSHS will continue to: promote giving vaccines in the medical home; use the statewide immunization registry; educate providers and the public; and implement reminder/recall systems.

Initiative: Medicaid Incentives for Healthy Behaviors

The Centers for Medicare and Medicaid Services (CMS) is conducting a grant-funded demonstration, Wellness Incentives and Navigation (WIN), to evaluate the effectiveness of providing incentives to Medicaid clients to adopt healthy behaviors and improve outcomes. DSHS and HHSC partnered to receive a \$9.9 million, 5-year grant, to be operated by DSHS. The project focuses on Medicaid managed care (STAR+PLUS) clients with behavioral health conditions, since they are more likely to suffer chronic physical co-morbidities, to experience debilitating chronic physical illnesses earlier in life, and to have elevated health care costs. WIN will be implemented in the Harris managed care service area, in partnership with the STAR+PLUS health maintenance organizations and other community stakeholders. The project will include 1,250 voluntary participants randomized into intervention and control groups and will be independently evaluated. WIN interventions:

- Wellness planning and navigation facilitated by trained, professional health navigators, who will 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 WIN participant; and
- More intensive Wellness Recovery Action Planning training for individuals with the most severe mental illnesses.

9.3.3. Improving the Health of Infants and Women

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

- Emphasize health promotion, primary care, disease prevention, and early intervention in a quality-oriented, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Improve access to effective behavioral health, prevention, and treatment services.
- Work with partners to develop public health strategies to improve outcomes and to contain health care costs.
- Ensure programs and initiatives recognize and address health disparities and disproportionality to improve outcomes across all programs.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Engage communities in developing service delivery systems, programs, and policies.

Discussion

Infant Mortality

Infant and maternal mortality and cancer impact thousands of Texas women and their families each year. Access to appropriate care and education throughout the life course, including preventive and prenatal care and cancer screening and treatment, helps reduce risks and improve outcomes. Despite major advances in medical care, poor birth outcomes continue to be a problem in the U.S. and Texas. The number of deaths to infants less than one year of age per 1,000 live births was 6 in Texas in 2009. The rate among African Americans has consistently been higher than other racial and ethnic groups, with 11.3 deaths per 1,000 live births in 2009. The leading causes of infant mortality are birth and genetic defects, disorders related to preterm birth and low birth weight, and sudden infant death syndrome. Risk factors include no prenatal care, maternal smoking and/or alcohol use, and inadequate weight gain during pregnancy.

Babies born preterm (before 36 weeks of gestation) have a greater risk of dying within their first year of life. There has been an increase in the number of babies born preterm over the past nine years in Texas. The percent of infants born preterm in recent years ranged from 12.6 percent in 2000, to 13.7 percent in 2003 and 2005. In 2009, 13 percent of Texas births were preterm, compared to 12.2 percent for the U.S. Preterm rates are also higher among African Americans in Texas (17.6 percent in 2009) than any other racial or ethnic group.

Breastfeeding Practices and Disparities

Breast milk benefits the health, growth, immunity, and development of infants. Mothers who breastfeed have a reduced risk of type 2 diabetes and breast and ovarian cancer. 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.

Breastfeeding practices vary considerably by a number of factors, including maternal race and ethnicity, education, age, and income. Studies show infants born to mothers with a college education were most likely to have ever been breastfed and to continue to be breastfed, while only about two-thirds of infants born to mothers with a high school degree or less were breastfed. Asian infants were most likely to ever be breastfed while non-Hispanic African-American infants were the least likely to ever be breastfed. Infants born to older mothers and those with higher household incomes were also more likely to be breastfed.

Maternal Mortality

Maternal mortality is often used as a measure of health and well-being of women across the globe. Researchers at the national and state level have found that maternal mortality is often underreported, particularly deaths of women occurring more than 42 days after the end of a pregnancy, indicating that more could be

happening later during the postpartum period than the maternal mortality ratio suggests. 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 potential underreporting, 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 8.3 deaths per 100,000 live births in 2000, to 24.6 deaths per 100,000 live births in 2010. 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. Almost 25 percent of women of childbearing age are obese and thus at higher risk for conditions such as diabetes and high blood pressure.

Breast and Cervical Cancer

Of the leading cancers diagnosed among Texas women, breast cancer is the most common and cervical cancer ranks seventh. An estimated 17,382 women will be diagnosed with breast and cervical cancer in 2012, with over 3,200 estimated to die from the disease. Surviving breast and cervical cancer depends on how early the cancer is detected. The best method to detect breast or cervical cancer in its early stages is through regular screening.

The DSHS Breast and Cervical Cancer Services (BCCS) program offers clinical breast examinations, mammograms, pelvic examinations, and Pap tests throughout Texas at no or low-cost to eligible women. BCCS is partly funded by the CDC National Breast and Cervical Cancer Early Detection Program. Since 1991, approximately 194,116 women have received breast cancer screenings and 195,849 women have received cervical cancer screenings.

Planned Actions

Healthy Texas Babies

The Healthy Texas Babies initiative helps communities decrease infant mortality using evidence-based interventions. The initiative, led by DSHS in collaboration with the HHSC and the Texas Chapter of the March of Dimes, involves community members, health care providers, and insurance companies. Activities focus on educating the public, providers, and patients, through:

- Evidence-based interventions led by local coalitions in communities identified at high risk for infant mortality and preterm birth;
- Development of a communications campaign to raise public awareness of the factors leading to infant mortality, health disparities, and preterm birth;

- Survey of hospitals to determine where neonatal intensive care units and obstetrical units are in the state and how DSHS can improve access to care for high-risk pregnancies;
- Collaboration between the Women, Infants, and Children (WIC) program and the March of Dimes to improve patient education on the importance of the last weeks of pregnancy;
- Provider education to reduce disparities in birth outcomes between racial and ethnic groups, improve adherence to national standards of care, and provide support for clinical decision-making; and
- Increased understanding of how to meet the needs of men in their roles as fathers and support father involvement through evidence-based initiatives.

Breastfeeding Promotion

Improving breastfeeding outcomes is integral to DSHS' overall efforts to promote better birth outcomes across the state. DSHS provides education and support through several areas of the agency, including the WIC program.

DSHS has numerous breastfeeding activities that are coordinated through the DSHS Infant Feeding Workgroup. DSHS will continue to invest in the following efforts to develop effective interventions: increased awareness of birthing facilities, Better by Breastfeeding/Right from the Start awareness campaign for hospitals, Texas Ten Steps certification program recognizing hospitals that have voluntarily adopted breastfeeding policies, breastfeeding trainings, WIC Every Ounce Counts campaign, Lactation Support Hotline, and Mother-Friendly Worksite initiatives. The initiatives target education of the public, providers, and mothers about the benefits of breastfeeding. DSHS provides support directly to breastfeeding mothers, and to birthing facilities and worksites to build an environment around the mother conducive to initiating and continuing breastfeeding.

Women's Health

DSHS will continue to support efforts to decrease maternal mortality rates and ensure women's access to primary and preventive health services throughout the lifespan, including breast and cervical cancer screening through the BCCS program. Receiving appropriate services during childbearing years, for example, impacts birth outcomes, thus building on the ongoing Texas Healthy Babies initiative.

DSHS will continue to monitor changes in health care services and policy, and potential impacts on women's health services. The agency will work with stakeholders to identify methods to ensure access to prenatal, preventive, and comprehensive health care, including breast and cervical cancer screening and diagnostic services. Additionally, DSHS will continue to promote local entities' utilization of community health workers to assist women in accessing maternal health, and primary and preventive health services.

9.3.4. Addressing the Evolving Profile of Individuals in Need of DSHS-Funded Services

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

- Emphasize health promotion, primary care, disease prevention, and early intervention in a quality-oriented, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Improve access to effective behavioral health, prevention, and treatment services.
- Promote the delivery of locally-driven health care that integrates both physical and behavioral health services.
- Work with partners to develop public health strategies to improve outcomes and to contain health care costs.
- Ensure programs and initiatives recognize and address health disparities and disproportionality to improve outcomes across all programs.

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

- Ensure policies and services that encourage responsibility and improve access to employment.
- Partner with persons with disabilities, including persons with mental illness, in overcoming barriers to full participation in the community and the labor market.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Work closely with faith- and community-based organizations to assist people in applying for nutrition, medical, and monetary assistance, and other service needs.
- Engage communities in developing service delivery systems, programs, and policies.

Discussion

As the population of Texas grows, and changes in state and federal health care policy and resources evolve, the profile of individuals in need of government-funded public health and primary and behavioral health services may concurrently shift.

Public Health

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 diseases are the leading causes of death in the U.S. and Texas as discussed in Section 9.3.2, Preventing Chronic Diseases and Infectious Diseases. Another remaining health issue is infant mortality, which can be addressed through a number of interventions and population-based efforts. Reduction in the infant mortality rate is a top priority for DSHS, as discussed in Section 9.3.3, Improving the Health of Infants and Women.

Mental Illness

Mental illness is a leading cause of disability in the U.S., Canada, and Western Europe. In general, 19 percent of the adult population in the U.S. has a mental disorder alone, during the course of one year; 3 percent have both mental and addictive disorders. In Texas, the 2010 estimated number of adults with serious and persistent mental illness was 488,520. DSHS-funded community mental health services (including NorthSTAR) served 157,131 adults in fiscal year 2010 and 45,060 children in fiscal year 2010.

Approximately 20 percent of children are estimated to have mental disorders with at least mild functional impairment. Federal regulations also define a sub-population of children and adolescents with more severe functional limitations, known as serious emotional disturbance (SED). Children and adolescents with SED comprise approximately 5-9 percent of children ages 9-17.¹ The 2010 estimated number of children in Texas with SED was 154,724.

Planned Actions

Collaboration with Local Health Departments

In accordance with newly revised Chapter 117 of the 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:

- Establishing and supporting the Public Health and Funding Policy Committee,
- Developing plans to transition from contractual agreements with local health entities to cooperative agreements,

¹ <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

- Providing direct support and technical assistance to local health entities by 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 accreditation through the national Public Health Accreditation Board.

Capacity and Utilization of Community-based Behavioral Health, Primary Care, and Public Health Services

DSHS will monitor and assess the impact of the changing health care environment on the agency, its programs, service providers, and service recipients. As the safety net system experiences shifts in resources and federal and/or state funding priorities, DSHS will make adjustments accordingly. Efforts will be made to ensure the availability of public health, primary care, and behavioral health services to populations that may not be eligible for coverage through Medicaid, Medicare, or the state Children's Health Insurance Program (CHIP). Additionally, DSHS will seek to make available evidence-based service delivery approaches that may not be covered by third-party insurance, but that, when combined with other treatment methodologies, demonstrate improved health status for service recipients.

Capacity of In-Patient Psychiatric Hospitals

DSHS operates and maintains state-owned facilities, which provide direct services 24 hours per day, 7 days per week to individuals requiring in-patient 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. They are committed to state hospitals for treatment and competency restoration. From fiscal year 2001 to fiscal year 2011, the percentage of forensic bed use has increased from 16 percent to 40 percent in all state hospitals, including a new mental health treatment facility in Montgomery County. Adjusting to the increasing forensic population has provided numerous challenges and has the potential to change the focus and direction of the state mental health hospital system.

The 419th District Court ruling on the *Floyd Taylor v. David Lakey, M.D.* lawsuit issued February 2, 2012, requires DSHS to transfer pretrial detainees confined in county jail prior to being admitted to a state mental hospital within 21 days after receiving a commitment order notice from a criminal court. Within 90 days of the order, 50 percent of detainees currently waiting in jail for a state mental hospital bed

longer than 21 days must be moved to an appropriate state hospital and all detainees currently waiting longer than 21 days must be moved within 120 days of the order. DSHS is considering several options to comply with the order that may impact both civil and forensic capacity.

9.3.5. Meeting Increased Regulatory Demands Due to Business Growth

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

- Work with partners to develop public health strategies to improve outcomes and to contain health care costs.

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 environment that supports accountability and innovation.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Engage communities in developing service delivery systems, programs, and policies.

Strategic Priority: Ensure 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, cost-effective, and customer-friendly.
- Recruit high quality employees.

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 2011, all regulatory strategies saw tremendous growth in the number of licensees; the overall increase was about 40 percent, exceeding the growth in the state's population. The total number of licenses overseen by DSHS is approaching 350,000.

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 rapidly growing number of licenses and resource constraints, the risk-based approach is becoming more 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 will mean that DSHS will no longer investigate some low-risk complaints, will refer more complaints to entities for self-investigation, and will perform fewer routine inspections.

Aligning Regulatory Resources to Meet Demands

DSHS has initiated an internal self-evaluation of all regulatory programs and functions to identify opportunities for improving the state's regulatory system. The self-evaluation includes examination of:

- The appropriate level of resources, including staffing, required to perform statutorily required regulatory activities;
- Risk matrices for inspections and complaint investigations timeframes;
- Potential administrative efficiencies and opportunities for programmatic restructuring;
- Potential modifications to regulatory functions aimed at prioritizing activities to those of highest risk for the protection of consumers and public health; and
- Potential improvements to the ability of the state to recover the costs of performing regulatory services by reducing programmatic costs, reviewing its fee structure, and identifying other potential revenue opportunities.

This information will be provided to a contractor for evaluation, verification, and delineation of recommended actions for consideration by DSHS. From the contractor's work product, a report will be submitted to legislative and state leadership prior to the 83rd Legislature, 2013.

9.3.6. Increasing Emphasis on Health Care Quality

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

- Emphasize health promotion, primary care, disease prevention, and early intervention in a quality-oriented, cost-effective system of care, improving outcomes for long-term public health and well-being.
- Work with partners to develop public health strategies to improve outcomes and to contain health care costs.

Strategic Priority: Encourage partnerships and community involvement.

- Develop partnerships with individuals, families, stakeholders, community organizations, providers, and others in the public to improve service delivery and ensure people receive timely, appropriate services.
- Engage communities in developing service delivery systems, programs, and policies.

Strategic Priority: Ensure 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, cost-effective, and customer-friendly.
- Encourage innovation and teamwork.

Discussion

DSHS has been increasingly involved in state efforts to improve the quality and safety of health care in Texas. Currently, DSHS is pursuing multiple initiatives that involve improved health care quality and outcomes.

Chapter 98 of the Texas Health and Safety Code, requires DSHS to compile and make available to the public a summary, by health care facility, of health care associated infections (HAIs) reported by the facilities. The 80th and 81st Texas Legislatures took steps toward improving patient safety. Examples include Senate Bill (S.B.) 288, 80th Legislature, Regular Session, 2007, and S.B. 203, 81st Legislature, Regular Session, 2009. Each of these initiatives share similar objectives: to assist consumers in making informed health care decisions and to minimize the administrative burden on facilities in reporting data.

Planned Actions

Potentially Preventable Hospitalizations

Adult Texans experienced almost 1.5 million potentially preventable hospitalizations (PPHs) from 2005 to 2010. These hospitalizations resulted in approximately \$39.5 billion in hospital charges, approximately \$2,100 for every adult Texan. To assist communities in addressing this issue, DSHS provides information to state, regional, and local stakeholders on the impact of PPHs in their geographical area of interest. The following ten conditions are classified as PPHs because hospitalization would potentially have not occurred if the individual had had access to, and/or cooperated with, out-patient health care: bacterial pneumonia, dehydration, urinary tract infection, angina (without procedures), congestive heart failure, hypertension, asthma, chronic obstructive pulmonary disease, diabetes short-term complications, and diabetes long-term complications.

The 82nd Legislature, Regular Session, 2011, appropriated \$2 million for DSHS to implement an initiative to reduce PPHs in 2012-13 biennium. DSHS successfully executed contracts with 16 counties to target specific PPH conditions. Funded sites are implementing community-coordinated, evidence-based interventions to reduce hospitalizations, and/or hospital charges among their adult county residents. For more information on PPHs, go to: <http://www.dshs.state.tx.us/ph>.

Health Care Associated Infections Reporting

Approximately 130,000 to 160,000 infections associated with health care are expected to occur annually in Texas at an estimated cost as high as \$2 billion. S.B. 288 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 health care facilities, establishing an advisory panel, providing education and training for health care facility staff, and providing accurate comparison of HAI data to the public to help individuals make informed decisions about choosing health care facilities.

Initiative: Preventable Adverse Events Reporting and Patient Safety

S.B. 203 requires the reporting of preventable adverse events (PAE). CMS has established 10 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 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 health care 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.

Healthcare Quality Steering Committee

DSHS has established a Healthcare Quality Steering Committee that is dedicated to establishing the DSHS role in improving health care quality in Texas. Activities include:

- Understanding the critical components of the health care quality operating environment and the interplay among the many elements of the multi-disciplinary, multi-sector field of health care quality;
- Collaborating with stakeholders to identify opportunities to work with other state agencies, state and national quality entities, and health care providers;
- Maximizing the use of data to improve the timeliness and usability of existing data within DSHS relevant to health care quality in Texas;
- Coordinating internal quality activities occurring in agency divisions; and
- Developing a plan for how DSHS will assist the Texas Institute of Health Care Quality and Efficiency with completing the assessment of all health-related data collected by the state, identifying all information available to the public, and determining how the public and health care providers currently benefit and could potentially benefit from health care cost and quality information.

9.4 Current Activities

9.4.1 DSHS Goal 1: Preparedness and Prevention Services

Goal 1 programs focus on the prevention of 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.

Community Preparedness

Target Population

Community preparedness serves the entire Texas population.

Service 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. Since 2005, DSHS has responded to 24 incidents that were either declared disasters or events of public health significance.

DSHS coordinates the distribution of grant funds from the 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:

- Develop, implement, and evaluate preparedness and response planning;
- Conduct exercises and drills to assure planning effectiveness;
- Enhance surveillance, epidemiology, and laboratory capacities;
- Establish and maintain the Public Health Information Network;
- Develop and implement effective risk communication strategies;
- Develop and evaluate workforce development for key public health professionals, infectious disease specialists, emergency personnel, health care providers and other response partners;
- Support hospitals and health care 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 has developed 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.

Initiative: *Ready or Not?* Campaign

The *Ready or Not?* public education campaign, originally funded through a CDC cooperative agreement and mandated by House Bill (H.B.) 1831, 81st Legislature, Regular Session, 2009, employs a multi-pronged strategy to reach as many Texans as possible with messages on how to prepare for, respond to, and recover from a disaster. Starting in the summer of 2010 and running through August 2011, the campaign, using \$3 million in general revenue funds, reached across Texas through the following tactics:

- Formative research,
- Paid advertising (television, radio, online, public service announcement placement),
- Earned media (press conference, radio tours with the DSHS Commissioner),
- Documentary video series: *Surviving Disaster: How Texans Prepare*
- Public outreach (public community events, video screenings, trainings/webinars, conference participation, outbound call center),
- Enhanced websites: www.TexasPrepares.org and www.TexasPrepara.org (tools to create disaster plans for individuals, communities and businesses), and
- Distribution of materials (brochures, emergency document bags, checklists).

Strategic priorities for the future include continued grass-roots marketing activities to educate Texas residents and communities on how to develop a disaster plan and new partnerships to promote the campaign and to increase awareness of the *Surviving Disaster* video series.

Health Promotion and Vital Records

Target Population

Health promotion and vital records functions serve the entire Texas population.

Service 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 analyze and distribute information on health and health care 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 that are occurring, 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 through the production of 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.

CHS also maintains DSHS library services, including managing the Medical and Research, Audiovisual, and Early Childhood Intervention/Rehabilitation Libraries; the Funding Information Center; the Institutional Review Board; and publications.

Vital Statistics Unit

Chapter 191 of the Health and Safety Code, requires DSHS to administer the registration of vital statistics for the State of Texas. The Vital Statistics Unit (VSU) maintains more than 47 million records of important events in Texans' lives, including births, deaths, marriages, divorces, adoptions, and paternity changes. VSU produces documents that federal and state entities use to establish identity, citizenship, ownership, entitlement to benefits, and passport travel authorizations. VSU is the fundamental source of natality, mortality, and demographic data by

registering these vital events, including births, deaths, fetal deaths, and suits affecting the parent-child relationship. VSU issues nearly one million records service requests annually.

The primary registration mechanism for birth and death vital events has moved from a paper-based system to what is now almost entirely electronic. The Texas Electronic Registrar (TER), an integrated, Internet-based system, is used by source providers to register records in an efficient and secure manner. VSU provides support to over 25,500 stakeholders, including physicians, medical examiners, justices of the peace, funeral directors, hospital birth clerks, and local registration officials. The TER system has allowed event registration times to be reduced from 35 to 5.5 days for birth records, and from 39 to 11 days for deaths. In addition to vital record registration, the TER system is utilized by VSU staff to manage and process customer orders, including fee tracking and management tasks.

Border Health

Target Population

Border health functions serve the 2.6 million Texans who live in 32 counties of the U.S.-Mexico border region of Texas.

Service Description

The Office of Border Health (OBH) is charged with promoting and protecting the health of border residents by reducing community and environmental health hazards along the Texas-Mexico border. OBH works in collaboration with communities and U.S. and Mexican local, state, and federal entities. OBH field staff work in border communities to facilitate a coordinated response to address public health concerns along the border. OBH core functions include: bi-national coordination (specifically serving as principal agency point of contact to Mexico), inter/intra-agency coordination of border health issues, and serving as a clearinghouse for border data and information. OBH works with a wide range of partners in this effort:

- Eight sister-city bi-national health councils,
- The U.S.-Mexico Border Health Commission (BHC),
- Border Governors Conference Health Table,
- Pan American Health Organization Border Field Office, and
- Offices of Border Health in Arizona, California, and New Mexico.

OBH also coordinates with the BHC's Healthy Border 2010 and 2020 programs and community-based projects addressing measurable border health objectives.

Through federal funding, the OBH enhances border public health preparedness with Mexico, including sharing of surveillance data and providing for appropriate training for public health personnel.

Immunizations

Target Population

Immunization services improve the health of all Texans.

Service Description

DSHS immunization activities improve quality of life and life expectancy by achieving and maintaining an environment free of vaccine-preventable diseases. Vaccines are a cost-effective public health disease control measure. Key strategies to increase vaccine coverage levels include:

- Promoting use of ImmTrac, the statewide immunization registry;
- Providing education about receiving immunizations in the medical home;
- Encouraging use of reminder/recall systems;
- Educating health care providers and the public about immunization services and their public health value; and
- Working with stakeholders to improve implementation of these strategies.

ImmTrac is a tracking and reporting tool for vaccines and antivirals. It is also used for disaster preparedness purposes. The registry contains a vast number of immunization histories:

- More than 99 million immunizations recorded,
- More than 6.6 million youth under the age of 18,
- More than 2.2 million children under the age of 6,
- More than 69,000 adults 18 years and older,
- More than 25,000 first responders or first responder family members 18 years and older,
- More than 18,000 antivirals entered as part of disaster response, and
- More than 1.2 million H1N1 vaccinations entered as part of disaster response.

DSHS immunization activities seek to increase vaccine coverage levels in both children and adults. In 2009, Texas was recognized by the CDC as the most improved state in immunization coverage levels, ranking 12th in the nation. Currently, DSHS is embarking on an immunization registry replacement project 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 sexually transmitted diseases (STDs), the program benefits all Texans in its focus on disease prevention.

Service 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 who are 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 also 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, development of 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:

- HIV/STD surveillance;
- HIV/STD prevention services;
- Delivery of medical and support services for persons living with HIV/AIDS, including HIV medications for low-income individuals; and
- Provision of notification and testing services for partners of individuals diagnosed with HIV/STD.

HIV Surveillance

The 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

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, jail health programs, STD clinics, and primary care clinics. Targeted testing programs focus on populations most at risk for HIV infection, and DSHS funds 24 partner agencies, including local health departments, community-based organizations, and universities for this work. Behavioral interventions focus on persons at highest risk for acquiring or transmitting HIV. 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. Partner services are conducted by ten local health departments and seven DSHS health service regions.

HIV Care and Treatment

The program allocates funds to local communities to provide medical and social support services for persons living with HIV and 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 2010, more than 35,000 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 16,711 clients with 353,194 prescriptions in fiscal year 2011.

Environmental and Injury Epidemiology and Toxicology

Target Population

The Environmental and Injury Epidemiology and Toxicology (EIET) Unit serves the entire Texas population.

Service 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 EIET Unit administers the Texas Environmental Health Institute (a legislatively mandated joint venture between DSHS and the Texas Commission on Environmental Quality). The Institute examines ways to identify, treat, manage, prevent, and reduce health problems associated with environmental contamination, and tracks trends for reportable occupational conditions.

The EIET Unit includes the child lead poisoning prevention program; the exposure, assessment, surveillance and toxicology group; and the injury and emergency

medical services (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.

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 2010, the program received 730,381 child blood lead reports representing information for 416,570 individual children. There were 972 children confirmed to have an elevated blood level. Many were referred for case management, and 307 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 2010, this group conducted public health assessments on sites potentially affecting 21,000 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 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 2010, the EMS/Trauma Registry processed 3,338,686 reports representing 1,925,303 individual records.

Zoonosis Control

Target Population

Zoonoses are diseases transmissible from animals to humans. Program activities target individuals and entities that are involved in animal control efforts or monitoring epidemic zoonotic diseases, and benefit the entire Texas population.

Service Description

Zoonosis Control protects the public's health through prevention and control of diseases transmitted between animals and humans, such as: plague, West Nile virus, rabies, Lyme disease, anthrax, brucellosis, malaria, and tularemia. Key services include:

- Distributing oral rabies vaccine baits to control rabies in certain wildlife species and thereby reducing exposure of people and domestic animals to rabies (at least 7.5 million vaccine baits to be distributed during 2013-17);
- 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, 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.

Service Description

Infectious disease activities are essential in improving the public health response to disasters or disease outbreaks. Key functions that support epidemiological and surveillance activities include:

- Monitoring and tracking more than 45 reportable infectious diseases 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 with, and providing technical assistance to local and regional health departments on appropriate methods to monitor diseases, investigate disease outbreaks, and conduct studies to identify newly emerging infectious diseases and their risk factors; and
- Developing and implementing systems to monitor health care associated infections and preventable adverse events to assess the magnitude of infections and events in populations and improve health care quality.

Tuberculosis Services

Target Population

TB prevention and control activities serve the entire Texas population.

Service Description

DSHS provides the following TB related activities:

- TB disease surveillance,
- Support for TB prevention and control activities in DSHS health service regions and local health departments,

- Provision of TB testing supplies and medications, and
- Regulation of 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 CDC as required. The surveillance system serves as a statewide registry of TB cases and their contacts. Information from the system is used as 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 7 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) located in San Antonio provides TB consultant services at no cost to health care 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.

Service Description

Individual, community, environmental, and system-level evidence-based changes promote healthier decisions and healthier communities and prevent chronic disease. Activities include: educating individuals on healthy life choices, outreach and community engagement to create healthy environments and communities, and access to clinical preventive services. Specific chronic diseases addressed include: cardiovascular disease, cancer, diabetes, obesity, Alzheimer's disease, asthma, and arthritis. DSHS engages in the following activities:

- Chronic disease surveillance and evaluation
- Local/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.

Coordinated Chronic Disease Prevention Program

Target Population

Through funds from the CDC, the Coordinated Chronic Disease Prevention Program targets individuals, families, and communities at risk or at high risk for chronic disease, with focus on heart disease, cancer, stroke, diabetes, arthritis, and their associated risk factors, and Texas populations with high rates of health disparities.

Service Description

The program works to improve the health and quality of life for individuals, families, and communities by creating healthy and safe communities, improving access to and coordination of community and clinical prevention services, empowering people to make healthier decisions, and eliminating health disparities. The program goals include:

- Reducing the burden of chronic disease in Texas through a coordinated approach to chronic disease prevention;

- Strengthening the collaboration among DSHS chronic disease prevention programs; and
- Improving the health and quality of life for individuals, families, and communities at risk or at high risk for chronic disease.

To achieve these outcomes, DSHS will:

- Provide leadership, strategic vision, and expertise to develop, coordinate, integrate, implement, and evaluate its chronic disease prevention programs and partners/stakeholders;
- Develop clear, coordinated chronic disease health messaging in Texas; and
- Develop a Coordinated Chronic Disease State Plan to support Texas in its goal of decreasing disparities, disability, cost, and death due to chronic disease throughout the state.

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.

Service Description

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 health care 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
- Health care systems changes to promote quality care and prevention efforts for providers, payers, and educators.

Transforming Texas: Healthy People in Healthy Communities

Target Population

The Community Transformation Grant, funded by the CDC, targets both general and special populations focused on communities less than 500,000 in population, especially rural, border, and frontier communities. Eighteen entities in thirty Texas communities have been funded in FY 2012 as part of this effort.

Service Description

The program works to improve the health and quality of life for individuals, families, organizations, and communities by creating healthy and safe communities, improving access to and integration of community prevention services and clinical services, empowering people to make healthier decisions, and eliminating health disparities.

The goals for *Transforming Texas* include:

- Reducing death and disability due to tobacco use by five percent;
- Reducing the rate of obesity by five percent; and
- Reduce death and disability due to heart disease and stroke by five percent.

To achieve these outcomes, evidence- and practice-based policy, environmental, and systems change interventions in three strategic directions have been implemented: tobacco-free living with a focus on secondhand smoke, healthy eating and active living, and utilization of high impact evidence-based clinical and other preventive services with a focus on high blood pressure and high cholesterol.

Nutrition, Physical Activity, and Obesity Program

Target Population

The Nutrition, Physical Activity, and Obesity Prevention Program targets both general and special populations in communities throughout the state.

Service Description

The program works to reduce the burden of death and disease related to obesity in Texas. The program administers an obesity-focused cooperative agreement from the CDC; monitors the nutrition and physical activity status of Texans to identify emerging problems; provides leadership and expertise to state-level stakeholders, partners, and groups; and provides training and technical assistance to communities to facilitate policy and environmental change. Specific activities include:

- Development and oversight of the Strategic Plan for the Prevention of Obesity in Texas;
- Statewide training to increase capacity for implementing that strategic plan and policy and environmental change activities;

- Oversight of CDC- and state-funded community interventions; and
- Training, guidance, and support of regional nutritionists' staff activities related to policy, systems, and environmental change in communities to prevent and control obesity.

School Health

Target Population

The School Health Program targets school-age children, parents, and school personnel.

Service Description

The School Health Program supports Texas schools in implementing coordinated school health programs through a variety of strategies. These strategies include working with strategic partnerships throughout the state to support school health initiatives, dissemination of school health information through the Friday Beat and other school health information to school health professionals through a detailed list-serve, and providing technical assistance to local school districts on coordinated school health, school health advisory councils and other health-related topics.

Safe Riders

Target Population

The Safe Riders traffic safety program serves low-income families throughout the state with children less than 14 years of age.

Service 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.

Service Description

Teen pregnancy is cited as a major reason for non-completion of school. Sixty percent of mothers nationwide who have a child before they turn 18 never graduate from high school. Additionally, teen mothers are more likely to live in poverty, come from poverty, and depend on welfare. This study cites that 80 percent of teen mothers receive welfare in the 10 years following a teen birth and 44 percent are still receiving welfare for 5 more years after that. Between 1991 and 2004, there have been more than 745,000 teen births in Texas, costing taxpayers a total of \$15.1 billion over that period. Texas contributes 12 percent of all of the teen births in the nation. Almost every single county in Texas is above the national average of 42.5 per 1,000 females for teen births. One in three Texas girls experience pregnancy before they turn 20. At 24 percent, Texas ranks higher than any other state in the proportion of teen births that are repeat births among females ages 15-19.

Abstinence education targets students in 5th through 12th grades to delay initiation of sexual activity as part of a continuum of services to decrease the teen birth rate and rate of sexually transmitted infections in youth ages 15 to 19. The program contracts for the provision of in-school and after school intervention. Resources include:

- Web-based resources for parents: www.power2talk and www.poderdehablar;
- *Sex Can Wait, Talking Can't* booklet/DVD for parents in Spanish and English;
- Web-based resources for youth at www.power2wait.com;
- Texas Youth Leadership Summit;
- Power2wait Toolkits for grades 4-8;
- Workshops provided by ESCs; and
- Regional Service Learning trainings.

Children with Special Health Care Needs Services Program

Target Population

The Children with Special Health Care Needs (CSHCN) Services Program serves individuals who meet certain medical and income eligibility. The program pays for health care benefits and services not covered by other payers. Support services also target the families of these individuals.

Service 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 health care benefits for children with extraordinary medical needs, disabilities, and chronic health conditions and people of any age with cystic fibrosis.

Health care benefits include a broad array of medical care and related services. The program contracts with community-based organizations in many parts of the state to provide case management, family support, community resources, and clinical

services. 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

Target Population

The Kidney Health Care (KHC) Program serves persons with end stage renal disease (ESRD) who meet specific income and other eligibility requirements.

Service Description

The KHC Program provides medical, drug, and transportation services to persons diagnosed with ESRD. Medical services (dialysis and access surgery) are provided through contractual agreements with hospitals, dialysis facilities, and physicians. The KHC Program provides payment for covered outpatient drugs and limited reimbursement for travel to receive services. In addition, the program pays monthly premiums for Medicare Parts A, 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.

Service Description

The 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.

Glenda Dawson Donate Life – Texas Registry

Target Population

Texans of all ages may register to become a donor. People younger than 18 years of age may sign up with the registry, but they must have parental consent to complete their registry enrollment.

Service Description

The Donate Life – Texas Registry provides Texans with a convenient way to register their intent to become organ, tissue, or eye donors upon their death. Registered organ procurement organizations, tissue banks, and eye banks may search the Internet-based registry on a case-by-case basis. Potential donors may

register online or in person at Texas Department of Public Safety driver license offices.

Laboratory Operations

Target Population

The DSHS public health laboratory operations serve all Texans.

Service Description

The DSHS public health laboratory provides analytical, reference, research, training, and educational services related to laboratory testing. Laboratory services include:

- 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;
- Women's Health Laboratory specialty services for preventive women's health and infectious disease screening;
- 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 1.5 million specimens and samples are processed per year including: screening 760,000 newborn blood spots for 29 disorders; testing 450,000 specimens as part of the Texas Health Steps program; testing 265,000 microbiological specimens for bacteria associated with communicable diseases, food-borne outbreaks, TB, influenza and other viruses, and rabies; and analyzing 27,000 drinking water samples.

Regional and Local Public Health Services and Systems

Target Population

The local and regional public health system serves all Texans.

Service Description

Local public health agencies and DSHS health service regions 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. Some of the public health issues addressed by the regional and local public health system include:

- Conducting activities associated with health education, promotion, and assessment of health disparities;
- Planning for and responding to local public health emergencies such as H1N1 disease outbreaks or hurricanes;
- Enforcing local and state public health laws;
- Performing communicable disease control measures, such as contact investigations for TB, HIV, and STDs; and
- Conducting active disease surveillance and epidemiological analysis.

9.4.2 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 health care, mental health care, and substance abuse services. Under this goal, DSHS also works through the Women, Infants, and Children (WIC) Program to ensure that good nutrition is accessible to Texans birth-5 years or women who are pregnant, breastfeeding, or postpartum. Finally, DSHS works to build health care capacity in communities by providing technical assistance and limited funding to organizations applying for certification as emergency medical service providers and state trauma centers.

Women, Infants, and Children Program

Target Population

The WIC Program provides services to a caseload of over 950,000 pregnant, breastfeeding, and post-partum women, and children from birth up to five years of age who meet the income and other eligibility requirements.

Service Description

The WIC Program is primarily administered through contracts with local health departments, cities, counties, hospital districts, hospitals, community action agencies, and other non-profit entities. Women, infants, and children participating in the WIC Program receive nutrition education, breastfeeding support, referrals to health care providers, and nutritious supplemental foods. Some WIC agencies provide immunizations free of charge to WIC clients. The WIC nutrition services are intended to be an adjunct to good health care during the critical times of a child's

early growth and development to prevent health problems and to improve consumers' health status.

The WIC Program strives to achieve a positive change in dietary habits that will continue after participation in the program has ceased. In October 2009, the Texas WIC Program food packages underwent a number of changes. The changes include the addition of new allowable foods, as well as changes in some of the current food items. In particular, the food package increased fiber by adding fresh and frozen fruits and vegetables, and reduced saturated fat and cholesterol by decreasing amounts of milk, eggs, and cheese. These modifications align the WIC food packages with the Dietary Guidelines for Americans and the current infant feeding practice guidelines of the American Academy of Pediatrics.

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. Participants reported that they appreciate the convenience, security, and anonymity afforded them by use of the WIC EBT cards. Texas WIC has over 600,000 active cards in circulation and processes an average of over \$1.5 million in claims daily from 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 meet specific income and other eligibility criteria.

Service 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 HIV screening in the family planning clinic setting.

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 health care entities, including local health departments, hospital districts, non-profit organizations, and university-based clinics.

Breast and Cervical Cancer

Target Population

This program serves women 18-64 years of age who are at or below 200 percent of the federal poverty level (FPL) and meet other eligibility requirements. Priority is given to women 50-64 years of age for breast cancer screenings and women 21-64

years of age who have never been screened or have not been screened in the past five years for cervical cancer.

Service Description

DSHS administers breast and cervical cancer control activities intended to reduce breast and cervical cancer mortality. The program ensures statewide delivery of breast and cervical cancer screening, diagnostic services, case management, and surveillance services. DSHS contractors provide a variety of services, including clinical breast examinations, mammograms, Pap tests, pelvic examinations, and diagnostic and case management services for women with abnormal test results.

Contractors include local and regional health departments, community health centers, 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 CHIP. In addition, Title V Block Grant funds are used to improve the health of mothers, children, and their families through population-based services.

Service Description

The Texas Title V Program provides funds for a wide range of activities supporting preventive and primary care services for pregnant women, mothers, infants, children, and adolescents. DSHS contracts with health care organizations and professionals across the state to provide family planning, dysplasia detection, prenatal care, well-baby care, laboratory services, and case management to families. 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 focus on a reduction in infant mortality through the Healthy Texas Babies initiative with support from various state partners including HHSC and the Texas Chapter of the March of Dimes. Efforts within the 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.

Child/Adolescent Health

Target Population

Child/adolescent health programs in Texas serve low-income children and adolescents, including parents as appropriate, as determined by specific program eligibility requirements.

Service Description

Child and adolescent health services include comprehensive and preventive health care administered through a variety of programs and funding sources. Related activities also include designing and implementing federally-mandated outreach materials to educate and train parents, child care providers, and early childhood professionals on health and safety issues.

Newborn Screening

In 2006, DSHS expanded the panel of disorders screened in newborns in Texas from 7 to 29 disorders, including newborn hearing screening. The goal of the program is to decrease the morbidity and mortality of infants born in Texas by providing:

- Accurate, fast, and high-quality screening laboratory analysis for practitioners;
- Follow-up clinical care coordination services;
- A statistical review of the program; 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. DSHS Oral Health 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 20 years of age 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 health care services and provide useful information for service recipients. DSHS provides the THSteps Online Provider Education campaign that includes more than 40 online courses on preventive health, mental health, oral health, and case management topics. This campaign offers free continuing education credit for providers and was nationally recognized by the Association of State and Territorial Health Organizations as a creative approach to public health needs by state health programs and initiatives.

Case Management for Children and Pregnant Women

The Case Management for Children and Pregnant Women Program provides services to children with a health condition/health risk, birth through 20 years of age, and to high-risk pregnant women of all ages, in order to encourage the use of cost-effective health and health-related care. 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. Direct case management services are provided by enrolled Medicaid providers and DSHS regional case management staff to assist eligible clients. DSHS central office and regional case management staff also provides training and support to approved providers.

Personal Care Services

In 2007, DSHS, at the direction of HHSC, began determining eligibility for a new Medicaid benefit, Personal Care Services. Children from birth through 20 years of age are eligible for Personal Care Services 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.

Genetics Program

The Genetics Program contracts for direct genetic services and population-based genetic projects. Genetics staff educates health care providers, consumers, and the public about the benefits of genetic services.

Primary Health Care

Target Population

The Primary Health Care program serves Texas residents at or below 150 percent of the FPL who are not eligible for other programs that provide the same services.

Service Description

Primary Health Care 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.

Service Description

The program is locally administered by counties, public hospitals, and hospital districts, with program oversight assigned to DSHS. Program staff assists counties in meeting their statutory indigent health care responsibilities by providing technical assistance and state funding for a portion of the counties' indigent health care costs.

Community Mental Health Services for Adults and Children

Target Population

The adult mental health priority population consists of adults who have severe and persistent mental illnesses (diagnoses of schizophrenia, bipolar disorder, or major depressive disorder) and significant functional impairment. It also includes persons who require crisis assessment and/or stabilization. The children's mental health priority population is children 3-17 years of age with a diagnosis of mental illness and who:

- Have a serious functional impairment;
- Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
- Are enrolled in special education because of a serious emotional disturbance.

Resiliency and Disease Management (RDM) provides a standard framework for ongoing services across the state. Those who are not prioritized for ongoing RDM 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 RDM is the approach

used to direct evidence-based services and supports to recipients. RDM is intended to provide treatment in sufficient amounts to facilitate recovery. Available services for adults include: medication management, psychosocial rehabilitation, psychotherapy, assertive community treatment, supported employment, supported housing, and case management. Available services for children include skills training, counseling, and wraparound case management.

Initiatives

Review of the Texas Public Behavioral Health System

Rider 71, 82nd Texas Legislature, Regular Session, 2011, requires DSHS to utilize a consultant to conduct a comprehensive analysis of the public behavioral health system in Texas. The Public Consulting Group is conducting the analysis, which focuses on two components: a comprehensive study of the current public behavioral health system in Texas, and short- and long-term recommendations for the Texas behavioral health system. As part of the rider, the Public Consulting Group has conducted a series of stakeholder meetings to gather input on the current behavioral health system regarding access to care, service delivery models, current service array, and funding for services.

The comprehensive review includes the identification of provider types delivering services, service delivery mechanisms, service offerings, and the subpopulations receiving services. A report, due to the Governor and Legislature in September 2012, will include the analysis of the current system and recommendations for improved access, service utilization, patient outcomes, and system efficiencies.

Improve the Measurement, Collection, and Reporting of Behavioral Health Client Outcome Data

Rider 65, 82nd Legislature, Regular Session, 2011, requires DSHS to report to the Legislature and the Governor's Office each year of the biennium its efforts, planned or implemented, to improve the measurement, collection, and reporting of behavioral health client outcome data. To address this rider, DSHS will implement new assessment tools for both children and adults. The child and adolescent tool is the Child and Adolescent Needs and Strengths and the adult tool is the Adult Needs and Strengths Assessment. Benefits include: greater assessment detail including a focus on the individual's needs and strengths and use of a nationally recognized and validated tool that will yield a reliable change index outcome measure.

Standardized training and ongoing certification will be required for all clinicians administering the new assessments. This initiative will require two years to complete the training, certify clinicians, make changes to information technology systems, and collect sufficient data for analysis. DSHS has received an extension of the deadline to implement usage of the new assessment tools and complete the final comparative analysis which is slated for completion by December 2014.

Youth Suicide Prevention

The Texas Youth Suicide Prevention Project provides awareness of suicide prevention and best practices in communities and schools; screening and referral services to youth in military families; and suicide prevention training in schools, educational systems, juvenile justice systems, foster care systems, and other youth support organizations, such as those involved with mental health, gay/lesbian/bisexual/ transgender and questioning youth, and substance abuse. The project is funded through the Substance Abuse and Mental Health Services Administration Garrett Lee Smith Youth Suicide Prevention Grant Program. Key partners are DSHS, the Center for Health Care Services in San Antonio, Mental Health America of Texas, and the Texas Suicide Prevention Council, a public/private collaboration of 19 state organizations and 28 local suicide prevention coalitions.

The purpose of the project is to reduce deaths by suicide and suicide attempts among Texas youth by developing and implementing the youth strategies of the Texas State Plan for Suicide Prevention and the National Strategy for Suicide Prevention. The goals of the project are to: provide information to the public about youth suicide, risk factors, and prevention; train health, school, and community representatives to identify and refer youth who are at risk of suicide; and screen youth in military families and refer those at risk.

H.B. 1386, 82nd Legislature, Regular Session, 2011, requires DSHS to work with Texas Education Agency to develop a list of suicide prevention programs based on best practices, for use in Texas public schools. The bill calls for each school district to include a suicide prevention plan in the District Improvement Plan. Sample district plans are being gathered to post on the www.TexasSuicidePrevention.org website along with the list of best practices.

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 Statistical Manual of Mental Disorders, Fourth Edition, criteria for substance abuse or dependence and who are medically indigent. In addition, state and federal law specifies priority risk groups, including: identified substance abusers infected with HIV and persons at risk for HIV, persons who use intravenous drugs, and women with substance use disorders who are pregnant and/or parenting or have had their children removed from the home because of a substance use disorder.

Service Description

A service continuum ranging from universal prevention to treatment has been developed to address substance use and abuse and is delivered through community

organizations that contract with the state. Prevention services are delivered using a comprehensive program design which 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 provide a regional library of resources and materials on the harmful effects of alcohol, tobacco, and other drug use. They also provide merchant education on the tobacco laws to retailer outlets located within their regions. 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 are provided in in-patient, residential, and out-patient settings.

Approximately 87 percent of Texas' funding for substance abuse services in fiscal year 2011 was provided by federal block grant funds, which include federal requirements for priority risk populations noted earlier.

NorthSTAR

Target Population

NorthSTAR services are for Medicaid-eligible and other individuals who meet eligibility criteria for community mental health or substance abuse services, and who reside in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties.

Service Description

NorthSTAR is an integrated behavioral health project that blends funding (Medicaid, mental health and substance abuse block grant funds, and state general revenue) from HHSC and DSHS to provide managed behavioral health care (mental health and substance abuse) services.

Tobacco Prevention and Control

Target Population

Tobacco prevention and control efforts benefit all Texans.

Service Description

The mission of the Tobacco Prevention and Control Program is to reduce the health effects and economic toll of tobacco. The goals of the program include:

- Prevent tobacco use among young people;

- Promote compliance and support adequate enforcement of federal, state, and local tobacco laws;
- Increase cessation among young people and adults;
- Eliminate exposure to secondhand smoke;
- Reduce tobacco use among populations with the highest burden of tobacco-related health disparities; and
- Develop and maintain statewide capacity for comprehensive tobacco prevention and control.

DSHS has implemented a variety of initiatives to prevent tobacco use and initiation and to place emphasis on 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.

Five local community 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 funded through Lubbock Cooper Independent School District, Fort Bend County, Travis County, Bexar County, and Northeast Texas Public Health District.

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 regionalized emergency health care systems in Texas.

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 health care services and designate provider shortage areas and medically underserved communities.

The J-1 Visa Waiver program, which places foreign physicians in medically underserved areas, helps communities develop the capacity to provide medical services to their citizens.

Emergency Medical Services (EMS) and Trauma Systems

DSHS builds community capacity to ensure the public's safety through EMS/trauma systems across the state. To ensure the availability of prompt and skilled emergency medical care, 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.

9.4.3 DSHS Goal 3: Hospital Facilities and Services

Goal 3 covers those direct services, mostly in-patient, 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 TB and other communicable diseases at the TCID, and primary health care at the Rio Grande State Center Outpatient Clinic.

State Mental Health Hospitals

Target Population

The State Mental Health Hospitals (SMHs) admit individuals who have a mental illness and either present a substantial risk of serious harm to self or others, or show a substantial risk of mental or physical deterioration. Special populations served include: children and adolescents, 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 10-17 years of age who are diagnosed as emotionally disturbed, who have a history of behavior adjustment problems, and who need a structured treatment program in a residential facility.

Service Description

The SMHH system includes nine state hospitals and the 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, 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 (OPC) 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 of the Texas population for medical emergencies and bioterrorism response.

Service Description

RGSC OPC 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 (breast and cervical cancer control program, breast diagnostics and image studies, STD screening),
- Diabetes and endocrinology clinic,
- Medical nutrition therapy and diabetes education, and
- Diagnostic radiology and lab services.

Texas Center for Infectious Disease

Target Population

TCID serves patients older than 16 years of age with a diagnosis of TB or Hansen's disease (leprosy) who require hospitalization or specialized services. Patients are referred by local health departments, private providers, local courts managing patients with infectious TB and Hansen's disease, and other states that have 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 in-patient 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 out-patient 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.

9.4.4 DSHS Goal 4: Consumer Protection Services

Goal 4 programs protect the health of Texans by ensuring high standards in the following areas: health care facilities, allied and mental health care, 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 health care facilities, credentialed professionals, and consumer safety products and services that affect the entire permanent and visiting population of Texas.

Service Description

The basic functions of regulatory services include:

- Developing and maintaining 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.

Currently, the total number of licenses overseen by DSHS is approaching 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. Additionally, the Regulatory Services Division includes the Office of EMS/Trauma Systems which provides trauma designation levels I-IV and primary and support stroke designation for hospitals. DSHS also has a disaster planning/homeland security role with regulated entities.

The discussion below describes the areas in which DSHS has a regulatory role, and it concludes with a description of a current review of the regulatory system.

Health Care Professionals

Eleven independent licensing boards are administratively attached to DSHS. These boards regulate the practices of allied and mental health professions, and they adopt and enforce rules. DSHS provides the administrative support for their operations. These independent boards govern the following professions:

- Speech language pathologists and audiologists,
- Athletic trainers,
- Marriage and family therapists,
- Professional counselors,
- Social workers,
- Fitters and dispensers of hearing instruments,
- Sex offender treatment providers,
- Orthotists and prosthetists,
- Dietitians,
- Midwives, and
- Medical physicists.

DSHS governs other 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/instructors,
- Opticians,
- Personal emergency response system providers,
- Sanitarians, and
- Dyslexia therapists.

The licensing process for health care professionals includes review 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 in-house 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 CMS contractor for the Clinical Laboratory Improvements Amendments Program, which regulates all laboratory testing (except research) performed on humans.

Food (Meat) and Drug Safety

Food and drug products are regulated to prevent the sale and distribution of contaminated, adulterated, and mislabeled foods and drugs. This includes retail food establishments, food and drug manufacturers, wholesale food and drug distributors, food and drug salvagers, meat and poultry processors and slaughterers, milk and dairy food processors, and molluscan shellfish processors and shippers. 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. Drugs, cosmetics, and medical device manufacturers, distributors, and salvagers are also regulated for consumer health and safety.

Environmental Health

Regulation includes the licensing, inspection, and monitoring of asbestos, lead, and mold abatement activities 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 school cafeterias, public swimming pools, youth camps, tattoo and body-piercing studios, and tanning studios.

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, nuclear power plants, 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. 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.

EMS/Trauma System

DSHS is responsible for developing, implementing, and evaluating a statewide emergency medical services (EMS) and trauma care system, including the designation of trauma and primary stroke facilities. Currently, 86 primary stroke facilities and 1 support stroke facility are designated in Texas. There are 257 designated trauma facilities in Texas. The Governor's EMS and Trauma Advisory Council advises DSHS on rules and standards for the system. It is anticipated that

additional disease modalities, such as acute cardiac events, may be considered for inclusion in the EMS/trauma system and designation programs in the future.

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.

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.

Initiative: Review of Regulatory System

H.B. 1, Rider 59, 82nd Legislature, Regular Session, 2011, requires the DSHS to evaluate its regulatory programs to:

- Determine where new fees can be assessed or existing fees increased to equal or exceed program appropriations,
- Perform an analysis of business operations and administrative processes supporting regulatory activities and develop recommendations for increasing efficiencies and decreasing cost, and
- Identify regulatory programs for which a reduction in the number of inspections and investigations would have the least impact on public and consumer safety.

To implement Rider 59, DSHS has initiated an internal assessment of all regulatory programs and functions to identify potential efficiencies, cost savings, and revenue increases. DSHS is also working with HHSC on an independent evaluation of its regulatory functions, to identify and develop recommendations directed at: increasing the effectiveness of business operations and administrative processes supporting regulatory activities; ensuring regulatory functions maximize consumer safety and public health without unduly burdening regulated entities; and improving the ability of the state to recover the costs of performing regulatory services.

9.5 Internal Assessment

9.5.1. Developing Quality Improvement Initiatives for Key Business Processes

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 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.

Initiative: National Public Health Improvement Initiative

In 2010, Texas received a National Public Health Improvement Initiative grant from the CDC to transform the Texas public health system and increase performance management capacity. The grant has a five-year timeline for implementing quality improvement activities across the agency and provides \$900,000 to the state during the first two years. A quality improvement team was formed to support the grant and develop an agency-wide quality improvement plan. The team has conducted an initial quality improvement self-assessment and quality improvement training. Funding is also supporting contract streamlining, improving Lead Registry data collection, making health data more accessible, and working with local health departments to increase readiness for public health accreditation.

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 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.

Cost-Containment Initiatives

DSHS continues to evaluate opportunities to contain costs. During the last legislative cycle the following areas were identified as potential cost containment strategies:

- Creating residential rehabilitation units,
- Reducing hospital discharge medications from two weeks to one week, and
- Phasing in medication management efforts in state hospitals.

DSHS will continue to work with the HHS System to consider additional cost containment strategies such as telework, reducing leased office space, and interagency co-location of office space.

Initiative: Privatization of a State Hospital

H.B. 1, Rider 63, 82nd Legislature, Regular Session, 2011, directed DSHS to develop a request for proposal to privatize one of the state mental health hospitals by September 2012. A request for information was posted, a public hearing was held, and a request for proposal was released in March 2012. Timelines have been developed for vendor selection to take place and privatization to occur on September 1, 2012. A quarterly status report to the Legislature is required.

9.5.2 Addressing Current and Future DSHS Workforce Needs

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 health care 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. The ability to survive competition in other sectors of the labor market will rest upon comprehensive strategic initiatives and optimizing workforce management.

Competitive Compensation

Clinicians of all types are in short supply nationally and in Texas, but are particularly acute for psychiatrists, child psychiatrists, psychiatric nurse practitioners, psychiatric physician assistants, and licensed substance abuse counselors. General physicians, pharmacists, and dentists are difficult to attract to psychiatric hospitals because of the low base pay and negative perceptions about working in the mental

health field. Market forces (high demand and limited supply) have increased competition among employers for the limited supply of clinicians available and have driven up the salaries in these fields.

Failure to augment salaries for certification, experience, rural areas, and high-risk duty stations tends to limit an already very thin clinician applicant pool. To recruit and maintain a high caliber workforce in these critical shortage areas, DSHS will continue to request additional resources, building on the initial steps made by the 82nd Legislature.

Training Opportunities

DSHS offers a six-week fall and spring semester of training named Grand Rounds, which consists of scholarly presentations to support workforce development and encourage a culture of learning and the integration of evidence into practice. Grand Rounds is open to any interested learner, including DSHS employees, HHS System employees, and community partners from local health departments and community health centers. The presentations are conducted weekly in Austin while being offered through live webinars to remote sites. Continuing education credit is normally available for multiple disciplines at no cost to the employees and other participants.

Aligning Organizational Structure and Staffing to Meet Future Needs

DSHS will continuously work to align its organizational structure and business processes to accommodate environmental shifts due to health policy changes and funding reductions (sequestration from the federal Budget Control Act of 2011). The agency will continuously assess the need to realign or consolidate functions, as well as recruit and retain employees with the skills needed to advance public health and behavioral health practice within the state.

9.5.3 Enhancing Health Data Quality and Security

There is an urgent need to create secure health information systems to support public health activities, improve health care quality, and control costs. Technological advances and associated governance structures will be required to address this issue. Additionally, changes will need to be made to existing statutes if data are to be shared within the agency.

Public health data are central to many health policy decisions. The collection, analysis, dissemination, and reporting of health data are scattered throughout DSHS and the HHS System. The DSHS Center for Health Statistics is central to most of the data flows within DSHS.

At present, there are statutory provisions prohibiting the linking of hospital discharge data with any other administrative or clinical datasets. This creates a challenge to devise metrics for quality or patient safety. Vital Statistics and other data are at risk for fraud, and 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 to 157 locations for 12,500 DSHS FTEs. Over the last four years, DSHS has made significant investment in the network infrastructure to ensure reliability, performance, security, and connectivity redundancy. Cost-containment strategies have been implemented to replace old technology using seat management and leasing strategies with current infrastructure at the desktop. Data security has been enhanced through the deployment of infrastructure for email filtering (for the prevention of external attacks such as virus, spyware, malware, and hackers), intrusion detection, software patch management, encryption, and laptop computer tracking. While much has been accomplished on the hardware infrastructure initiatives, the remaining challenge is significant.

The strategic focus is shifting to availability, quality, accessibility, security, and sharing of data. Systems currently being re-engineered or remediated 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.

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 (HIE) 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 health care 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.

Health Information Technology Governance

The HIT Executive Steering Committee is in the process of developing strategic health information governance and direction. The focus includes:

- Establishing formal DSHS leadership and governance of health information;
- Establishing a framework for HIT policy and health data information management at DSHS;
- Defining roles, responsibilities, and lines of authority;
- Developing a process to align DSHS policies with state and federal policies and standards, as well as industry standard technology;
- Defining strategic uses of health information to support decision-making and agency reporting;
- Defining the framework, policies, and standards that govern uses of health information within DSHS and with partners; and
- Defining the roadmap for achieving DSHS' long term objectives for use of health information.

Privacy of Health Data

The HIT Executive Steering Committee is addressing health data management policy as one component of the HIT 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 that 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 HHSC in the implementation of a System-wide data-loss prevention (DLP) solution. The DLP solution will enable 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.

Initiative: Security of Birth Records

H.B. 1, Rider 72, 82nd Legislature, Regular Session, 2011, directed DSHS to establish a work group to evaluate the security of birth records to protect Texas residents from identity theft and reduce fraud in vital records. DSHS will consult with, and include in the group, representatives from the Governor's Office, the U.S.

Department of Homeland Security, the Texas Department of Public Safety, local registrars, the Texas State Auditor's Office, the identity management solutions industry, and other government entities as necessary. The work group will:

- Evaluate the effectiveness and security of the state's birth record information system;
- Evaluate the feasibility of restructuring and upgrading the birth record information system and documents with advanced technology to prevent fraud and reduce inefficiency;
- Identify the roles and responsibilities of DSHS, local governments, and others in a central issuance birth record information system; and
- Identify 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.

Rider 72 requires DSHS to submit to the Governor and the Legislature a report regarding the results of the study and recommendations for legislation for the 83rd Legislature, Regular Session, 2013, along with recommendations for changes to the Texas Administrative Code needed to implement a recommended birth record information system and more secure documents.

9.5.4 Addressing Infrastructure Needs

Ensuring a well-maintained DSHS facilities infrastructure is necessary to provide a safe and secure environment for DSHS clients and workforce.

The 10 mental health facilities are campus-style settings composed of more than 500 buildings ranging in age from 14 to 154 years, with the majority built between 1930 and 1975. Deterioration of one building system often causes accelerated deterioration of another, which may result in accelerated 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 difficult and costly.

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.

To prepare for the future, each facility will be master-planned to identify current and future needs and the most efficient use of the buildings, infrastructure, and land over established time periods. Efficiencies will be gained through smaller, consolidated campuses. Planned renovations of existing buildings to meet programmatic needs and increase staff efficiencies, construction of new buildings, and demolition of buildings no longer needed will reduce the overall infrastructure, maintenance, and energy costs.

Moreton Building Recladding Project

The Robert D. Moreton Building is a 22-year-old, 122,000-square-foot office building on the DSHS main campus. The exterior skin includes precast concrete panels that have undergone a delayed ettringite formation process causing movement of panels from their installed position. In investigations, this process has been determined to be approximately ten percent complete, resulting in an expected further reaction to a point of partial or complete failure of the panels. Precast panels are showing stress in locations causing spalling of small pieces, panel expansion, and water leaks. It has been determined through an extensive engineering study that the exterior panels of the building must be recladded to prevent interior damages and extend the life of the building.

Engineering cost evaluations determined that the repair of the building skin presents a better life cycle cost than the replacement of the existing building with a like structure. The Texas Facilities Commission prepared a preliminary project budget estimate of \$20,000,000 to repair the building and directed DSHS to request an exceptional item, which was approved by the 82nd Legislature, Regular Session, 2011. The cost of construction for the identified scope of work is estimated to be \$14.5 million, with the balance of costs associated with architectural and engineering services related to design; management; furniture, fixtures, and equipment; and moving/relocation. The funding did not include renovation costs to space to be occupied by relocated employees during the project. If renovations are required, DSHS and the displaced programs must fund this expense.

The relocation of staff is scheduled from March 2012 through July 2012; the construction is scheduled from August 2012 through August 2014; and the return to the building is scheduled from March 2014 through July 2014.

Chapter 10

Goals, Objectives, and Strategies

The following presentation of goals, objectives, and strategies, by agency, reflects the structure proposed to the Legislative Budget Board (LBB) and the Governor's Office of Budget, Planning, and Policy (GOBPP). This structure will later incorporate performance measures and become the framework for the agency's budget.

10.1 Health and Human Services Commission

10.1.1 Goal 1: HHS Enterprise Oversight and Policy

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

Objective 1-1. Enterprise Oversight and Policy. By 2011, HHSC will improve the business operations of the Health and Human Services System to maximize federal funds, improve efficiency in system operations, improve accountability and coordination throughout the System, and ensure the timely and accurate provision of eligibility determination services for all individuals in need of Health and Human Services System programs.

Strategy 1-1-1. Enterprise Oversight and Policy. Provide leadership and direction to achieve an efficient and effective health and human services system.

Strategy 1-1-2. Integrated Eligibility and Enrollment. Provide accurate and timely eligibility and issuance services for financial assistance, medical benefits, and food stamps.

Objective 1-2. HHS Consolidated System Support Services. By 2011, HHSC will improve the operations of the Health and Human Services System through the coordination and consolidation of administrative services.

Strategy 1-2-1. Consolidated System Support. Improve the operations of health and human service agencies through coordinated efficiencies in business support functions.

10.1.2 Goal 2: Medicaid

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

Objective 2-1. Medicaid Health Services. By 2011, HHSC will administer programs that provide medically necessary health care in the most appropriate, accessible, and cost-effective setting.

Strategy 2-1-1. Aged and Medicare. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to Medicaid-aged and Medicare-related persons.

Strategy 2-1-2. Disability-Related. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to Medicaid-eligible individuals with disabilities and blindness.

Strategy 2-1-3. Pregnant Women. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting for Medicaid-eligible pregnant women.

Strategy 2-1-4. Other Adults. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting for TANF-eligible adults and adults eligible under the health care reform expansion.

Strategy 2-1-5. Non-Disabled Children. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to newborn infants, foster care children, and other Medicaid-eligible children.

Objective 2-2. Other Medicaid Services. By 2011, HHSC will provide policy direction and management of the state's Medicaid program and maximize federal dollars.

Strategy 2-2-1. Non-Full Benefits. Provide medically necessary health care to Medicaid-eligible recipients for services not covered under the insured arrangement including: federally qualified health centers, undocumented persons, school health, and related services.

Strategy 2-2-2. Medicaid 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. Provide accessible premium-based health services to certain Title XVIII Medicare-eligible recipients.

Objective 2-3. Medicaid Support. By 2011, HHSC will improve the quality of services by serving as the single state Medicaid agency.

Strategy 2-3-1. Medicaid Contracts and Administration. 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

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

Objective 3-1. CHIP Services. By 2011, HHSC will ensure health insurance coverage for eligible children in Texas.

Strategy 3-1-1. CHIP. Provide health care to eligible uninsured children who apply for insurance through CHIP.

Strategy 3-1-2. CHIP Perinatal Services. Provide health care to eligible perinates whose mothers apply for insurance through CHIP.

Strategy 3-1-3. CHIP Prescription Drugs. Provide prescription medication to CHIP-eligible recipients (includes Immigrant Health Insurance and School Employee Children Insurance), as provided by their treating physician.

Strategy 3-1-4. CHIP Contracts and Administration. Set the overall policy direction of the state 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. By 2011, HHSC will provide appropriate support services that address the employment, financial, and/or nutritional needs of eligible persons.

Strategy 4-1-1. TANF Grants. Provide TANF grants to eligible low-income Texans.

Strategy 4-1-2. Refugee Assistance. Assist refugees in attaining self-sufficiency through financial, medical, and social services, and disseminate information to interested individuals.

Objective 4-2. Other Support Services. By 2011, HHSC will promote safety, self-sufficiency, and long-term independence for those living with domestic violence or other adverse circumstances.

Strategy 4-2-1. Family Violence Services. Provide emergency shelter and support services to victims of family violence and their children, educate the public, and provide training and prevention support to institutions and agencies.

Strategy 4-2-2. Alternatives to Abortion. Provide pregnancy support services that promote childbirth for women seeking alternatives to abortion.

10.1.5 Goal 5: Program Support

Objective 5-1. Program Support.

Strategy 5-1-1. Central Program Support.

Strategy 5-1-2. IT Program Support.

Strategy 5-1-3. Regional Program Support.

10.1.6 Goal 6: Information Technology Projects

Objective 6-1. Information Technology Projects.

Strategy 6-1-1. TIERS.

10.1.7 Goal 7: Office of Inspector General

Objective 7-1. Integrity and Accountability. By 2011, HHSC will improve health and human services programs and operations by protecting them against fraud, waste, and abuse.

Strategy 7-1-1. Office of Inspector General. Investigate fraud, waste, and abuse in the provision of all health and human services, enforce state law relating to the provision of those services, and provide utilization assessment and review of both clients and providers.

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 by the end of fiscal year 2013, 100 percent of eligible children and their families have access to the quality early intervention services resources and supports they need to reach their developmental goals as outlined in the Individual Family Service Plan.

Strategy 1-1-1. ECI Services. Administer a statewide comprehensive system of services to ensure that eligible infants, toddlers and their families have access to the resources and support they need to reach their service plan goals.

Strategy 1-1-2. ECI Respite Services. Ensure that resources are identified and coordinated to provide respite service to help preserve the family unit and prevent costly out-of-home placements.

Strategy 1-1-3. Ensure Quality ECI Services. Ensure the quality of early intervention services by offering training and technical assistance, establishing service and personnel standards, and evaluating consumer satisfaction and program performance.

Objective 1-2. Services for Blind Children. Ensure 90 percent of eligible blind and visually impaired children and their families will receive blind children's vocational discovery and development services as developed in their individual service plans by the end of fiscal year 2013.

Strategy 1-2-1. Habilitative Services for Children. Provide information and training for blind and visually impaired children and their families so these children have the skills and confidence to live as independently as possible.

Objective 1-3. Autism Services. To provide services to Texas children ages 3-8 diagnosed with autism spectrum disorder.

Strategy 1-3-1. Autism Program. To provide services to Texas children ages 3-8 diagnosed with autism spectrum disorder.

10.3.2 Goal 2: Persons with Disabilities

DARS will provide persons with disabilities quality services leading to employment and living independently.

Objective 2-1. Rehabilitation Services—Blind. To provide by the end of FY 2013, quality rehabilitation services for eligible persons who are blind or visually impaired and subsequently place in employment 68.9 percent of those persons that received planned vocational rehabilitation services consistent with informed consumer choice and abilities. Additionally, to provide quality consumer-directed independent living services for eligible persons who are blind or visually impaired.

Strategy 2-1-1. Independent Living Services—Blind. Provide quality, consumer-directed independent living services that focus on acquiring skills and confidence to live as independently as possible in the community for eligible persons who are blind or visually impaired.

Strategy 2-1-2. Blindness Education. Provide screening, education, and urgently needed eye-medical treatment to prevent blindness.

Strategy 2-1-3. Vocational Rehabilitation—Blind. Rehabilitate and place persons who are blind or visually impaired in competitive

employment or other appropriate settings, consistent with informed choice and abilities.

Strategy 2-1-4. Business Enterprises of Texas. Provide employment opportunities in the food service industry for persons who are blind or visually impaired.

Strategy 2-1-5. Business Enterprises of Texas Trust Fund. Administer trust funds for retirement and benefits program for individuals licensed to operate vending machines under Business Enterprises of Texas (estimated and nontransferable).

Objective 2-2. Deaf and Hard of Hearing Services. To increase the number of persons (who are deaf or hard hearing) receiving quality services by 10 percent by the end of fiscal year 2013.

Strategy 2-2-1. Contract Services—Deaf. To administer an array of services to persons who are deaf or hard of hearing, including but not limited to: communication access, training, educational programs, testing interpreters, regulating interpreter certifications, and the STAP (Specialized Telecommunications Assistance Program) services.

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 level and certify accordingly, and to regulate interpreters to ensure adherence to interpreter ethics.

Strategy 2-2-3. Telephone Access Assistance. Ensure equal access to the telephone system for persons with a disability (estimated and nontransferable).

Objective 2-3. General Disabilities Services. To provide by the end of FY 2009, quality vocational rehabilitation services to eligible persons with general disabilities and subsequently place in employment 55.8 percent of those persons that received planned vocational rehabilitation services consistent with informed consumer choice and abilities. Additionally, to provide quality consumer-directed independent living services to persons with significant disabilities who have been determined eligible.

Strategy 2-3-1. Vocational Rehabilitation—General. Rehabilitate and place people with general disabilities in competitive employment or other appropriate settings, consistent with informed consumer choice and abilities.

Strategy 2-3-2. Independent Living Centers. Work with independent living centers and the State Independent Living Council (SILC) to establish the centers as financially and programmatically

independent from the Department of Assistive and Rehabilitative Services and financially and programmatically accountable for achieving independent living outcomes with their clients.

Strategy 2-3-3. Independent Living Services—General. Provide consumer-driven and DARS counselor-supported independent living services to people with significant disabilities statewide.

Strategy 2-3-4. Comprehensive Rehabilitation. Provide consumer-driven and counselor-supported Comprehensive Rehabilitation Services for people with traumatic brain injuries or spinal cord injuries.

10.3.3 Goal 3: Disability Determination

DARS will enhance service to persons with disabilities by achieving accuracy and timeliness within the Social Security Administration Disability Program guidelines and improving the cost-effectiveness of the decision making process in the disability determination services.

Objective 3-1. Accuracy of Determination. To achieve annually through 2013 the decisional accuracy of 90.6 percent and timeliness of 125 days as measured by Social Security Administration Disability Program guidelines.

Strategy 3-3-1. Disability Determination Services (DDS). Determine eligibility for federal Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits.

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 Foster Day Care. Provide purchased day care services for foster children where both or the one foster parent works full-time.

Strategy 2-1-4. TWC Relative Day Care. Provide purchased day care services for relative and other designated caregivers who work full-time.

Strategy 2-1-5. TWC Protective Day Care. Provide purchased day care services for children living at home to control and reduce the risk of abuse/neglect and to provide stability while a family is working on changes to reduce the risk.

Strategy 2-1-6. Adoption Purchased Services. Provide purchased adoption services with private child-placing agencies to facilitate the success of service plans for children who are legally free for adoption, including recruitment, screening, home study, placement, and support services.

Strategy 2-1-7. Post-Adoption Purchased Services. Provide purchased post-adoption services for families who adopt children in the conservatorship of DFPS, including casework, support groups, parent training, therapeutic counseling, respite care, and residential therapeutic care.

Strategy 2-1-8. Preparation for Adult Living (PAL) Purchased Services. Provide purchased adult living services to help and support youth preparing for departure from DFPS substitute care, including life skills training, money management, education/training vouchers, room and board assistance, and case management.

Strategy 2-1-9. Substance Abuse Purchased Services. Provide purchased residential chemical dependency treatment services for adolescents who are in the conservatorship of DFPS and/or parents who are referred to treatment by DFPS.

Strategy 2-1-10. Other CPS Purchased Services. Provide purchased services to treat children who have been abused or neglected, to enhance the safety and well-being of children at risk of abuse and neglect, and to enable families to provide safe and nurturing home environments for their children.

Strategy 2-1-11. Foster Care 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 2-1-12. 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. 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 Client 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.

Strategy 6-1-5. 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 Coordinated Services. Plan and implement programs to ensure preparedness and rapid response to bioterrorism, natural epidemics, and other public health and environmental threats and emergencies. Coordinate essential public health services through public health regions and affiliated local health departments. Coordinate activities to improve health conditions on the Texas Mexico border and to reduce racial, ethnic, and geographic health disparities throughout Texas.

Strategy 1-1-2. Health Registries, Information, and Vital Records. Collect, analyze, and distribute information on health and health care, and operate birth defects, trauma, and cancer registries, poison control network and environmental investigations. Maintain a system for recording, certifying, and disseminating information on births, deaths, and other vital events in Texas.

Objective 1-2. Infectious Disease Control, Prevention and Treatment. To reduce the occurrence and control the spread of preventable infectious diseases.

Strategy 1-2-1. Immunize Children and Adults in Texas. Implement programs to immunize children and adults in Texas.

Strategy 1-2-2. HIV/STD Prevention. Implement programs of prevention and intervention including preventive education, case identification and counseling, HIV/STD medication, and linkage to health and social service providers.

Strategy 1-2-3. Infectious Disease Prevention, Epidemiology and Surveillance. Implement programs and develop measures to prevent, detect, track, investigate, control, or treat tuberculosis, hepatitis C, outbreaks of infectious diseases, and the spread of animal-borne diseases in humans. Administer the Refugee Health Screening Program.

Objective 1-3. Health Promotion, Chronic Disease Prevention, and Specialty Care. To use health promotion for reducing the occurrence of preventable chronic disease and injury, to administer abstinence education programs, and to administer service care programs related to certain chronic health conditions.

Strategy 1-3-1. Health Promotion and Chronic Disease Prevention. Develop and implement community interventions to reduce health risk behaviors that contribute to chronic disease and injury. Administer service programs for Alzheimer's disease.

Strategy 1-3-2. Abstinence Education. Increase abstinence education programs in Texas.

Strategy 1-3-3. Kidney Health Care. Administer service programs for kidney specialty care.

Strategy 1-3-4. Children with Special Health Care Needs. Administer service program for children with special health care needs.

Strategy 1-3-5. Epilepsy Hemophilia Services. Administer service programs for epilepsy and hemophilia.

Objective 1-4. Laboratory Operations. To operate a reference laboratory in support of public health program activities.

Strategy 1-4-1. Laboratory Services. Provide analytical laboratory services in support of public health program activities, Women's Health Services and the South Texas Health Care Center.

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 through community based providers.

Strategy 2-1-1. Provide WIC Services: Benefits, Nutrition Education & Counseling. Administer nutrition services, including benefits, for eligible low income women, infants, and children (WIC) clients, nutrition education, and counseling.

Strategy 2-1-2. Women and Children’s Health Services. Provide easily accessible, quality and community-based maternal and child health services to low income women, infants, children, and adolescents.

Strategy 2-1-3. Family Planning Services. Provide family planning services for adolescents and women.

Strategy 2-1-4. Community Primary Care Services. Develop systems of primary and preventive health care delivery in underserved areas of Texas.

Objective 2-2. Provide behavioral health services. To support services for mental health and for substance abuse prevention, intervention, and treatment.

Strategy 2-2-1. Mental Health Services for Adults. Assure availability of and access to appropriate services in the community for adults with serious mental illness.

Strategy 2-2-2. Mental Health Services for Children. Provide supports and services for children with mental health needs and their families.

Strategy 2-2-3. Community Mental Health Crisis Services.

Strategy 2-2-4. NorthSTAR Behavioral Health Waiver. Provide mental health and substance abuse inpatient and outpatient services using a managed care model for adults and children.

Strategy 2-2-5. Substance Abuse Prevention, Intervention, and Treatment. Implement prevention and intervention services to reduce the risk of substance use, abuse and dependency; to interrupt illegal substance use by youth and adults and reduce harmful use of legal substances by adults. Implement a continuum of community and family based treatment and related services for chemically dependent persons. Optimize performance quality and cost efficiency through the managing and monitoring of contracted services.

Strategy 2-2-6. Develop a Statewide Program to Reduce the Use of Tobacco Products. Develop and implement programs of education, prevention, and cessation in the use of tobacco products.

Objective 2-3. 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. Develop and enhance regionalized emergency health care systems.

Strategy 2-3-3. Indigent Health Care Reimbursement (UTMB).

Reimburse the provision of indigent health services through the deposit of funds in the State-owned Multicategorical Teaching Hospital Account.

Strategy 2-3-4. County Indigent Health Care Services. Provide support to local governments that provide indigent health care services.

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 Disease (TCID).

Provide for more than one level of care of tuberculosis, infectious diseases, and chronic respiratory diseases at Texas Center for Infectious Diseases.

Strategy 3-1-2. South Texas Health Care System. Provide for more than one level of care of tuberculosis and other services through South Texas Health Care System.

Strategy 3-1-3. Mental Health State Hospitals. Provide specialized assessment, treatment, and medical services in state mental health facility programs.

Objective 3-2. Provide Private Owned Hospital Services. To provide for the care of persons with mental illness through privately owned hospitals.

Strategy 3-2-1. Mental Health Community Hospitals. Provide inpatient treatment, crisis assessment, and medical services to adults and children served in community hospitals.

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. Design and implement programs to ensure the safety of food, drugs, and medical devices.

Strategy 4-1-2. Environmental Health. Design and implement risk assessment and risk management regulatory programs for consumer products, occupational and environmental health, and community sanitation.

Strategy 4-1-3. Radiation Control. Design and implement a risk assessment and risk management regulatory program for all sources of radiation.

Strategy 4-1-4. Health Care Professionals. Implement programs to issue licenses, certifications, and other registrations of health care professionals, and to ensure compliance with standards.

Strategy 4-1-5. Health Care Facilities. Implement programs to license/certify, monitor compliance, and provide technical assistance to health care facilities.

Strategy 4-1-6. Texas Online. Estimated and Nontransferable.

10.5.5 Goal 5: Indirect Administration

Objective 5-1. Manage Indirect Administration.

Strategy 5-1-1. Central Administration.

Strategy 5-1-2. Information Technology Program Support.

Strategy 5-1-3. Other Support Services.

Strategy 5-1-4. Regional Administration.

10.5.6 Goal 6: Capital Items

Objective 6-1. Manage Capital Projects.

Strategy 6-1-1. Laboratory (Austin) Bond Debt. Service bond debt on reference laboratory.

Strategy 6-1-2. Capital Repair and Renovation: Mental Health Facilities. Conduct maintenance and construction projects critical to meeting accreditation/certification standards and to ensuring the safety of consumers.

Additional copies are available from:
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The electronic strategic plan is compatible with JAWS and other screen readers. For additional accommodations, please contact DARS at cper@dars.state.tx.us.