
**TEXAS HEALTH AND HUMAN
SERVICES SYSTEM**

2010 REPORT ON CUSTOMER SERVICE

**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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TEXAS HEALTH AND HUMAN SERVICES SYSTEM 2010 REPORT ON CUSTOMER SERVICE

EXECUTIVE SUMMARY

This “Report on Customer Service” is prepared in response to Section 2114.002 of the Government Code, which requires that Texas state agencies biennially submit to the Governor’s Office of Budget Planning and Policy and the Legislative Budget Board information gathered from customers about the quality of agency services. This report reflects the cooperative efforts of the five Texas Health and Human Services (HHS) agencies that comprise the HHS enterprise: the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), the Texas Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC).

The HHS enterprise is in the process of adopting a new system vision that provides a renewed emphasis on customer service. The new HHS system vision is: a consumer-focused health and human services system that provides high quality, cost-effective services resulting in improved health, safety, and greater independence for Texans.¹ HHS assessments of customer satisfaction provide useful feedback on how customers rate HHS services. This report provides the results of two types of assessments of HHS customer satisfaction:

- a biennial enterprise-wide survey that assesses the satisfaction of children with special health care needs (CSHCN) customers of each HHS agency, and
- fifteen surveys conducted by individual HHS agencies of specific groups of their customers.

The HHS agencies are using these customer ratings as they analyze how the system can improve its customer service.

Enterprise Customer Satisfaction Survey

HHS agencies collaborated on an enterprise-wide survey of children with special health care needs (CSHCN) customers in each HHS agency. CSHCN are defined by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau as, “those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”² All five HHS agencies serve CSHCN customers through a variety of programs.

¹ Health and Human Services System Strategic Plan 2011-2015.

² <http://mchb.hrsa.gov/cshcn05/>. Last viewed 4/21/2010.

The HHS agencies decided to focus the 2010 enterprise customer satisfaction survey on CSHCN customers after a 2008 Texas Pediatric Society (TPS) and Texas Medical Association (TMA) stakeholder forum recommended that HHS agencies survey CSHCN to determine how well available services are meeting their needs.

HHSC contracted with the Survey Research Center (SRC) at the University of North Texas to conduct a telephone survey of CSHCN customers. In March through May 2010, SRC interviewed a random sample of CSHCN customers (ages 21 and under) who were enrolled in the following HHS programs in state fiscal year 2009:³

- DADS: Medically Dependent Children’s Program (4,414 enrollees)
- DARS: Early Children’s Intervention Program youth on Medicaid (35,022 enrollees)
- DFPS: Substitute Care Services program youth with a physical disability (13,950 enrollees)
- DSHS: Title V Children with Special Healthcare Needs Services Program (2,909 enrollees)
- HHSC: Personal Care Services (6,135 enrollees).

The CSHCN customers for each agency were divided into two age groups: under age 18 and ages 18 through 21. If the youth was under age 18, SRC conducted the telephone survey with the youth’s parent or guardian. If the youth was ages 18 through 21, SRC interviewed the youth (if possible).

The 2010 questionnaire included three HHS agency-specific customer satisfaction questions asking the degree to which the customer agreed: that they are satisfied with the benefits they received from the agency, that the length of time they waited to receive benefits was reasonable, and that it wasn’t difficult to get needed benefits.⁴

Response Rate

There were 1,078 people interviewed. The overall survey response rate was 19 percent. The response rate was higher for DADS (25 percent) and DFPS (20 percent) and lower for DARS (17 percent), DSHS (15 percent), and HHSC (16 percent).

Findings

The report presents combined findings for the included HHS programs and separate findings for each HHS agency. The findings for all five customer groups were combined to reflect the combined results of customers’ experiences at each agency. These combined results do not represent customer satisfaction across the HHS system for the following reasons.

³ Individuals were excluded from the samples if they turned 22 during the survey period.

⁴ These agency-specific questions are part of a larger survey about how well available services meet the needs of CSHCN. The larger survey is an adapted version of two surveys used nationally: the National Survey of Children with Special Health Care Needs and the PedsQL. The survey was conducted by the University of North Texas Survey Research Center. It is anticipated that the report will be available late in the summer of 2010.

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- Respondents were asked about their satisfaction with the specific agency program provided by HHSC, DFPS, DADS, DARS, or DSHS and not with the HHS system.
 - Each agency’s customers have an equal weight in the summary statistics, regardless of the number of customers in the CSHCN program included for that agency.
 - The survey was limited to participants in specific programs for CSHCN. The survey did not include all HHS programs that serve children with special health care needs.

To summarize the results for each agency, those who “agreed” or “somewhat agreed” were combined for each question.

Of all customers in the surveyed DADS, DARS, DFPS, DSHS, and HHSC programs combined:

- 93 percent were satisfied with the benefits they received from the DADS, DARS, DFPS, DSHS, or HHSC programs,
- 81 percent felt the length of their wait for benefits was reasonable, and
- 80 percent indicated it was not difficult to get needed benefits.

Of customers in the DADS Medically Dependent Children’s Program (MDCP):

- 96 percent were satisfied with the benefits they received,
- 52 percent felt the length of their wait for benefits was reasonable, and
- 64 percent indicated it was not difficult to get needed benefits.

Of customers in the DARS Early Children’s Intervention Program (ECI) program customers on Medicaid:

- 94 percent were satisfied with the benefits they received,
- 95 percent felt the length of their wait for benefits was reasonable, and
- 89 percent indicated it was not difficult to get needed benefits.

Of customers in the DFPS Substitute Care Services (SCS) program customers with a physical disability:

- 88 percent were satisfied with the benefits they received,
- 86 percent felt the length of their wait for benefits was reasonable, and
- 78 percent indicated it was not difficult to get needed benefits.

Of customers in the DSHS Title V Children with Special Healthcare Needs (CSHCN) Services Program:

- 92 percent were satisfied with the benefits they received,
- 88 percent felt the length of their wait for benefits was reasonable, and
- 88 percent indicated it was not difficult to get needed benefits.

Of customers in HHSC Personal Care Services (PCS):

- 96 percent were satisfied with the benefits they received,
- 85 percent felt the length of their wait for benefits was reasonable, and
- 81 percent indicated it was not difficult to get needed benefits.

These customer satisfaction findings indicate that very large proportions of the CSHCN customers in the included programs were satisfied with the benefits they received once they obtained program benefits. Also, for most of the agencies, large proportions of the customers thought the length of time they waited for benefits was reasonable and that it was not difficult (or was easy) to get benefits.

For most of the included programs, customers were more likely to report being satisfied with the benefits they received than they were to report that the length of time they waited for benefits was reasonable. This is not a surprising finding. Many HHS programs have funding constraints that limit the availability of benefits. This result cannot be interpreted accurately without considering the supply versus the demand for each program's benefits. HHS agencies will look for ways to decrease program wait times and improve customer service to help those waiting for benefits understand the situation.

Similarly, customers in each of the included programs were more likely to report being satisfied with the benefits they received than they were to report that it was not difficult (or it was easy) to get benefits. This result is likely to be influenced by wait times, and an accurate interpretation would have to consider the supply versus demand for each program's benefits as described above. However, HHS programs will re-examine the application process to determine if there are any ways to make it easier for customers. HHS programs re-examine the application process regularly, and the renewed emphasis on customer service will involve taking a fresh look for ways to streamline the process.

Individual Agency Surveys

HHS agencies independently conduct surveys that include questions about customer satisfaction with specific agency programs and services. Part two of this report presents the descriptions and major findings of the following surveys. These survey results also present important information about customer satisfaction with services provided by HHS agencies.

Texas Department of Aging and Disability Services (DADS)

- 2009 Long-Term Services and Supports Quality Review (LTSSQR)
- Nursing Facility Quality Review (NFQR) in Texas 2009 survey report

Department of Assistive and Rehabilitative Services (DARS)

- Division for Blind Services (DBS) Customer Service Survey
- Division Rehabilitation Services (DRS) Vocational Rehabilitation Consumer Satisfaction Survey
- DRS Independent Living Services Consumer Satisfaction Survey

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- Early Childhood Intervention Family Survey Results SFY2009

Department of Family and Protective Services (DFPS)

- Adult Protective Services Community Satisfaction Survey
- Improving the Quality of Services to Youth in Substitute Care: A Report on Surveyed Youth in Foster Care SFY2007, Texas Department of Family and Protective Services, September 2008

Department of State Health Services (DSHS)

- The Children with Special Health Care Needs (CSHCN) Services Program 2009 Parent Survey Report
- The Children with Special Health Care Needs (CSHCN) Services Program 2009 Provider Survey Report
- The Children with Special Health Care Needs (CSHCN) Services Program 2009 Community Resource Coordination Groups Survey Report

Health and Human Services Commission (HHSC)

- The Children's Health Insurance Program (CHIP) in Texas: The Disenrollee Survey SFY2008
- The Children's Health Insurance Program (CHIP) in Texas: The Established Enrollee Survey Report SFY2008
- The Children's Health Insurance Program (CHIP) in Texas: The New Enrollee Survey SFY2008
- Texas STAR+PLUS Enrollee Survey Report SFY2009⁵

⁵ STAR+PLUS is a Texas Medicaid managed care program designed to provide health care, acute and long-term services and support through a managed care system. <http://www.hhsc.state.tx.us/starplus/Overview.htm>. Last viewed 5/21/10.

INTRODUCTION

This “Report on Customer Service” is prepared in response to Section 2114.002 of the Government Code, which requires that Texas state agencies biennially submit to the Governor’s Office of Budget Planning and Policy and the Legislative Budget Board information gathered from customers about the quality of agency services. This report reflects the cooperative efforts of the five Texas Health and Human Services (HHS) agencies that comprise the HHS enterprise: the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), the Texas Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC).

The 2003 restructuring of HHS programs and services provided many opportunities for the HHS agencies to consolidate, integrate, and better coordinate an array of administrative and program services under the leadership and oversight of HHSC.⁶ This report is evidence of HHS agencies’ continuing interest in integration and consolidation of services and functions to improve the quality and efficiency of services provided to HHS customers in Texas.

On-Going Customer Service Activities and Functions

The HHS enterprise is in the process of adopting a new system vision that provides a renewed emphasis on customer service. The new HHS system vision is: a consumer-focused health and human services system that provides high quality, cost-effective services resulting in improved health, safety, and greater independence for Texans.⁷ Three important processes will help ensure that HHS agency operations are consistent with this vision: the strategic planning process, the activities of the HHSC Office of the Ombudsman, and each HHS agency’s Center for Consumer and External Affairs.

Strategic Planning Process

The enterprise strategic plan facilitates the implementation of the HHS vision using strategic priorities for the health and human services system. An HHS enterprise strategic priority is to “deliver the highest quality of customer service.” The strategic plan also presents the strategies the enterprise will use for achieving the strategic priorities. The focus on customer service continues throughout the strategic plan.⁸

The strategic planning process involves examining HHS services to be sure they are aligned with the vision and priorities of the enterprise. The array of HHS services is based on the strategic plan. An appendix to this report presents a description of services provided to customers from each agency by strategic plan budget strategy.⁹

⁶ The restructuring was mandated by House Bill 2292, passed by the 78th Texas Legislature in 2003.

⁷ Health and Human Services System Strategic Plan 2011-2015.

⁸ Health and Human Services System Strategic Plan 2011-2015.

⁹ See Appendix A, Customer Inventories by Agency. This information is presented in accordance with Chapter 2113.002(a) of the Government Code.

HHSC Office of the Ombudsman

HHSC's Office of the Ombudsman (OO) assists the public when the agency's normal complaint process cannot or does not satisfactorily resolve issues.¹⁰ The mission of OO is to serve as an impartial and confidential resource, assisting consumers with health and human services-related complaints and issues.

Consumer and External Affairs

Each HHS agency also has a Consumer and External Affairs (CEA) area to handle customer service functions and ensure the involvement of consumers and stakeholders in improving agency services and communications. The CEA offices work closely with the HHSC OO in an effort to ensure close coordination of on-going customer service efforts among HHS agencies.

Assessing Customer Satisfaction

Each biennium, HHS agencies work together to develop an enterprise-wide survey to assess the satisfaction of customers of each HHS agency. In addition, HHS agencies survey specific groups of their customers. This report provides results from both types of assessments of customer satisfaction.

Enterprise Customer Satisfaction Surveys

In 2006, HHS agencies conducted the first enterprise-level customer satisfaction survey. The survey included a unique group of enrollees identified by each agency. The survey questionnaire included questions about service access and choice, staff knowledge and courtesy, complaint handling, quality of information and communications, and internet use. HHS agencies conducted a comparable survey in 2008, and issued a 2008 customer satisfaction report that included a comparison of the results of the two surveys.

For the 2010 enterprise customer satisfaction survey, a different approach was taken. HHS agencies collaborated on an enterprise-wide survey of children with special health care needs (CSHCN) enrollees in each HHS agency. CSHCN are defined by the Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau as, "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."¹¹ All five HHS agencies serve CSHCN customers through a variety of programs.

A 2008 Texas Pediatric Society (TPS) and Texas Medical Association (TMA) stakeholder forum recommended that HHS agencies survey children with special health care needs (CSHCN) to determine how well available services are meeting the needs of this group of children. The HHS

¹⁰ The HHSC Office of the Ombudsman was created by the 78th Texas Legislature and established in 2004.

¹¹ <http://mchb.hrsa.gov/cshcn05/>. Last viewed 4/21/2010.

agencies convened and decided to focus the 2010 enterprise customer satisfaction survey on CSHCN customers in each HHS agency. The 2010 questionnaire included three HHS agency-specific customer satisfaction questions that were also used in the 2006 and 2008 Customer Satisfaction surveys: overall satisfaction with the benefits or services received from the agency, the difficulty customers had in getting needed benefits or services, and the length of time customers waited to receive benefits or services.¹² The latter two questions were selected because results from the 2008 survey showed that a lower proportion of customers were satisfied with these aspects of service delivery.

HHS Agency Surveys

Each HHS agency also conducts customer surveys for specific agency programs. These customer surveys typically include an assessment of the customer's satisfaction with the services provided by the program. Summaries of the surveys and their major findings are provided in this report.

¹² These agency-specific questions are part of a larger survey about how well available services meet the needs of CHSCN. The larger survey is an adapted version of two surveys used nationally: the National Survey of Children with Special Health Care Needs and the PedsQL. The survey was conducted by the University of North Texas Survey Research Center. It is anticipated that the report will be available late in the summer of 2010.

REPORT FORMAT

This 2010 Customer Satisfaction Report has two parts. Part one focuses on the HHS enterprise survey of CSHCN customer satisfaction. HHSC contracted with the Survey Research Center at the University of North Texas to conduct the survey. Survey results are presented for each agency and for all five agencies combined. The survey results provide important insights into CSHCN customer satisfaction with HHS agency services and service delivery, and have implications for HHS agency services to CSHCN.

Part two of the 2010 Customer Satisfaction Report presents summaries of the results of customer surveys conducted by DADS, DARS, DFPS, DSHS, and HHSC. Each summary includes the main findings of the survey and, if available, a link to the full report. These results also present important information about customer satisfaction with services provided by HHS agencies.

PART 1 – HHS ENTERPRISE CUSTOMER SATISFACTION SURVEY

The Texas Health and Human Services Commission (HHSC) contracted with the Survey Research Center (SRC) at the University of North Texas to conduct a telephone survey of youth who were enrolled in State of Texas health and human services programs for youth with special health care needs. This report describes these customers' satisfaction with agency services.

The survey included customers enrolled in services provided by at least one of the five State of Texas health and human services agencies:

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

Customer satisfaction results are presented for all groups of customers included in the survey combined across the five state agencies. Results are also presented separately for each agency. This report presents findings for 1,078 collected interviews.

I. METHODOLOGY

Population

Five groups of children with special health care needs (CSHCN) were identified by Texas HHS agencies for this Customer Satisfaction Survey. These CSHCN customers (ages 21 or under) were enrolled in the following HHS programs in state fiscal year 2009.¹³

- DADS: Medically Dependent Children’s Program (MDCP; 4,414 enrollees)
- DARS: Early Children’s Intervention Program youth on Medicaid (ECI; 35,022 enrollees)
- DFPS: Substitute Care Services program youth with a physical disability (SCS; 13,950 enrollees)
- DSHS: Title V Children with Special Health Care Needs Services Program (CSHCN; 2,909 enrollees)
- HHSC: Personal Care Services (PCS; 6,135 enrollees)

Sample Design

HHSC provided SRC with a population data file for each of the five agencies. SRC removed youth duplicated within each agency’s data. Table A shows, for each agency, the delivered population sizes and the proportion of the population in each age group.

Table A
Population Distributions

Age Groups for Each Agency	Population	Population Proportion
DADS MDCP		
Under age 18	3,867	87.6%
Ages 18-21	547	12.4%
DARS ECI (only youth on Medicaid)		
Under age 18	35,022	100.0%
Ages 18-21	-	-
DFPS SCS (only youth with a physical disability)		
Under age 18	12,520	89.7%
Ages 18-21	1,430	10.3%
DSHS CSHCN Services Program		
Under age 18	2,153	74.0%
Ages 18-21	756	26.0%
HHSC PCS		
Under age 18	4,810	78.4%
Ages 18-21	1,325	21.6%
Total	62,430	

¹³ Individuals were excluded from the samples if they turned 22 during the survey period.

SRC drew two random samples from each unduplicated agency file, one for each age group. SRC oversampled to allow for not being able to obtain valid contact information for some sample members and for other sample members who would not respond to the survey. After each agency's sample was selected, SRC compared the agency samples to identify youth who were in more than one agency sample (i.e., first name, last name, and birth date were the same in more than one sample). SRC randomly selected the agency sample in which the individual would remain and deleted the duplicates from the other agency samples.

SRC combined the agency samples to create an unduplicated sample for the survey. The unduplicated sample of 19,158 youth was sent for National Change of Address (NCoA) processing. This sample was also sent to a vendor to identify working numbers, landline numbers and cell phone numbers. After the information from the NCoA and the vendor was added to the data files, SRC drew the final random samples for the survey by agency and age range.

SRC contracted with its vendor, Marketing Systems Group, to match addresses with phone number databases to try to obtain phone numbers for sample members whose agency records did not include a valid phone number. Youth for whom SRC could not find valid phone numbers remained in the sample. Most of these sample members had an opportunity to participate in the survey because SRC sent 8,630 sample members a pre-notification letter describing the survey and encouraging them to call SRC's toll-free number to participate. Sample members added toward the end of the study were not sent a pre-notification letter. The pre-notification letter was in English and Spanish.

Data Collection

Customers were divided into two age groups: youth up to age 18, and youth ages 18 through 21. If the youth was under age 18, SRC conducted the telephone survey with the youth's parents or guardian. If the youth was in the "18 through 21" age group, SRC interviewed the youth, if possible. Some youths in the "18 through 21" age group had a disability that made it difficult to participate directly in the interview. In those situations, SRC interviewed the youth's parent or guardian.

Trained telephone interviewers who had previous experience in telephone surveys conducted the survey. Each interviewer completed an intensive general training session. The purposes of general training were to ensure that interviewers understood and practiced all of the basic skills needed to conduct interviews and that they were knowledgeable about standard interviewing conventions. The interviewers also attended a specific training session for the project. The project training session provided information on the background and goals of the survey. Interviewers practiced administering the questionnaire to become familiar with the questions.

All interviewing was conducted from a centralized telephone bank in Denton, Texas. Interviews were conducted in English and Spanish. An experienced telephone supervisor was on duty at all times to supervise the administration of the sample, monitor for quality control, and handle any other problems. Data for the survey were collected from March 19, 2010 through May 16, 2010.

Questionnaire

The telephone interview questionnaire included three customer satisfaction questions to determine:

- whether it wasn't difficult/it was easy to get the benefits or services needed from the agency,¹⁴
- whether the length of time the customer waited to receive benefits or services was reasonable, and
- whether the customer was satisfied with the benefits or services received from the agency.

The three customer satisfaction questions were followed by several questions used nationally to assess how well all available services are meeting the needs of youth with special health care needs. This report included only the results from the three customer satisfaction questions. Results from the additional questions will be reported separately.

Response Rate

Table B shows the number of interviews completed in each group against the population. At the 90 percent confidence level, each agency has a margin of error that is approximately ± 6 percent or smaller.

Table C shows the response rate for each agency. Sample numbers were drawn from the population. "Invalid contact information" includes records that were unable to be contacted for one of several reasons including: wrong phone number, disconnected phone number, fax/modem line, deceased, or incomplete contact information. This was the final status of the cases even after an attempt was made to look-up telephone numbers. The "raw response rate" was calculated using the "sample drawn" count in the denominator. The "adjusted response rate" (excluding those without valid telephone contact information) ranged from a low of 12.5 percent for DSHS CSHCN Program youth under age 18 to a high of 28.2 percent for DADS MDCP youth ages 18-21.

The cooperation rate was 53.6 percent of the eligible, contacted households.¹⁵ This proportion does not address respondents who answered some questions but refused to answer others.

²The wording of this question was slightly different for two age groups. The parent or guardian of youth under age 18 answered the question, "It wasn't difficult to get the benefits or services needed." Youth ages 18-21 or their parent or guardian answered the question, "It was easy to get the benefits or services needed."

¹⁵ The cooperation rate was calculated using the American Association for Public Opinion Research cooperation rate definition, $COOP3 = (\text{Interviews}) / (\text{Interviews} + \text{Partial Interviews} + \text{Refusals})$.

Table B
Interviews Completed

Respondent	Population	Population Proportion	Interviews Conducted ¹⁶	Sample Proportion
DADS MDCP				
Under age 18	3,867	87.6%	225	85.9%
Ages 18-21	547	12.4%	37	14.1%
DARS ECI (only youth on Medicaid)				
Under age 18	35,022	100.0%	213	100.0%
Ages 18-21	-	-		
DFPS SCS (only youth with a physical disability)				
Under age 18	12,520	89.7%	221	90.9%
Ages 18-21	1,430	10.3%	22	9.1%
DSHS CSHCN Program				
Under age 18	2,153	74.0%	109	63.4%
Ages 18-21	756	26.0%	63	36.6%
HHSC PCS				
Under age 18	4,810	78.4%	138	73.4%
Ages 18-21	1,325	21.6%	50	26.6%
Total				
	62,430		1,078	

¹⁶ With this sample size, approximately 90 percent of the results will be within approximately 6 percent of what the results would have been if the entire population had been interviewed.

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**Table C
Response Rate**

Respondent	Population	Sample Drawn	Invalid Contact Information	Valid Contact Information	Interviews Conducted	Raw Response Rate	Adjusted Response Rate ¹⁷
DADS MDCP							
Under age 18	3,867	1,525	622	903	225	14.8	24.9
Ages 18-21	547	186	55	131	37	19.9	28.2
		1,711	677	1,034	262	15.3	25.3
DARS ECI (only youth on Medicaid)							
Under age 18	35,022	2,335	1,104	1,231	213	9.1	17.3
Ages 18-21	-	-					
		2,335	1,104	1,231	213	9.1	17.3
DFPS SCS (only youth with a physical disability)							
Under age 18	12,520	1,899	785	1,114	221	11.7	19.8
Ages 18-21	1,430	306	216	90	22	10.2	24.4
		2, 205	1,001	1,204	243	11.0	20.2
DSHS CSHCN Program							
Under age 18	2,153	1,247	372	875	109	8.7	12.5
Ages 18-21	756	443	189	254	63	14.2	24.8
		1,690	561	1,129	172	10.2	15.2
HHSC PCS							
Under age 18	4,810	2,340	1,330	1,003	138	5.9	13.8
Ages 18-21	1,325	619	417	209	50	8.0	23.9
		2,959	1,747	1,212	188	6.4	15.5
Total	62,430	10,900	5,090	5,810	1,078	9.9	18.6

¹⁷ Every interviewee did not answer every question, so the number of respondents to specific questions will be different.

Non-Response Analysis

A non-response analysis of the survey was conducted to examine differences in the distribution of several demographic categories between those who responded to the survey and those in the sample who did not (including those who did not have valid contact information, those who could not be contacted, those who refused, and those whom you did not try to contact because you already had enough responses). If part of a demographic group was underrepresented then it may impact a finding when differences by demographic variables were statistically significant. The data were not weighted for this analysis.

- For the DADS MDCP sample, the average age of respondents was 10.94 years old and the average age of non-respondents was 10.39 years old ($F=2.581$; $df=1$; 1,709).
- Race/ethnicity was unknown for 42 respondents and 252 non-respondents as these data were missing from the population data file. Region was unknown for 22 respondents and 138 non-respondents.
- As shown in Table D, statistically significant differences were observed for the ethnicity variable ($X^2=5.225$, $df=5$).

Table D
Comparison of Response Rates by Demographic Characteristics in Population Data File:
DADS MDCP (n=1,711)

Demographic Groups	Counts		Percentages	
	Responded	Did Not Respond	Responded	Did Not Respond
Age of youth				
Under age 2	2	18	0.8	1.2
2 to 4	25	173	9.5	11.9
5 to 7	55	282	21.0	19.5
8 to 12	77	461	29.4	31.8
13 to 17	66	366	25.2	25.3
18 to 21	37	149	14.1	10.3
Gender of youth				
Male	160	820	61.1	56.6
Female	102	629	38.9	43.4
Ethnicity of youth*				
White	133	604	50.8	41.7
African American	17	125	6.5	8.6
Hispanic	48	372	18.3	25.7
Other	22	96	8.4	6.6
Unknown	42	252	16.0	17.4

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Demographic Groups	Counts		Percentages	
	Responded	Did Not Respond	Responded	Did Not Respond
Region				
1 Panhandle	8	63	3.1	4.3
2 North Plains	9	29	3.4	2.0
3 North Central	78	383	29.8	26.4
4 Northeast	12	89	4.6	6.1
5 East	4	58	1.5	4.0
6 Southeast	35	230	13.4	15.9
7 Central	15	94	5.7	6.5
8 Southwest	50	209	19.1	14.4
9 West	8	37	3.1	2.6
10 Far West (Mountain)	4	21	1.5	1.4
11 Rio Grande Valley	17	98	6.5	6.8
Unknown	22	138	8.4	9.5

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

- For the DARS ECI sample, the average age of respondents was 2.38 years old and the average age of non-respondents was 2.51 years old ($F=3.172$; $df=1$; 2,335).
- Race/ethnicity was unknown for 1 non-respondent as this data was missing from the population data file.
- As shown in Table E, statistically significant differences were observed for ethnicity ($X^2=21.552$ ***, $df=4$) and region ($X^2=22.954$ *, $df=10$).

Table E
Comparison of Response Rates by Demographic Characteristics in Population Data File:
DARS ECI Youth on Medicaid (n=2,335)

Demographic Groups	Counts		Percentages	
	Responded	Did Not Respond	Responded	Did Not Respond
Age of youth				
Under age 2	44	401	20.7	18.9
2 to 4	169	1,721	79.3	81.1
Gender of youth				
Male	126	1,280	59.2	60.3
Female	87	842	40.8	39.7
Ethnicity of youth***				
White	70	459	32.9	21.6
African American	33	321	15.5	15.1
Hispanic	102	1,306	47.9	61.5
Other	8	35	3.8	1.6
Unknown	0	1	0.0	0.0

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Demographic Groups	Counts		Percentages	
	Responded	Did Not Respond	Responded	Did Not Respond
Region*				
1 Panhandle	8	126	3.8	5.9
2 North Plains	8	72	3.8	3.4
3 North Central	54	435	25.4	20.5
4 Northeast	9	72	4.2	3.4
5 East	16	58	7.5	2.7
6 Southeast	38	409	17.8	19.3
7 Central	19	248	8.9	11.7
8 Southwest	26	296	12.2	13.9
9 West	6	57	2.8	2.7
10 Far West (Mountain)	17	155	8.0	7.3
11 Rio Grande Valley	12	194	5.6	9.1

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

- For the DFPS SCS sample, the average age of respondents was 8.60 years old and the average age of non-respondents was 10.08 years old ($F=12.856^{**}$; $df=1; 2,203$).
- Region was unknown for 3 respondents and 41 non-respondents as these data were missing from the population data file.
- As shown in Table F, statistically significant differences were observed for the age variable ($X^2=16.557^{**}$, $df=5$) and the ethnicity variable ($X^2=7.967^*$, $df=3$).

Table F
Comparison of Response Rates by Demographic Characteristics in Population Data File:
DFPS SCS Youth with a Physical Disability (n=2,205)

Demographic Groups	Counts		Percentages	
	Responded	Did Not Respond	Responded	Did Not Respond
Age of youth**				
Under age 2	33	168	13.6	8.6
2 to 4	52	351	21.4	17.9
5 to 7	37	229	15.2	11.7
8 to 12	45	398	18.5	20.3
13 to 17	54	532	22.2	27.1
18 to 21	22	284	9.1	14.5
Gender of youth				
Male	131	1,107	53.9	56.4
Female	112	855	46.1	43.6
Ethnicity of youth*				
White	93	644	38.3	32.8
African American	76	628	31.3	32.0
Hispanic	64	646	26.3	32.9
Other	10	44	4.1	2.2

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Demographic Groups	Counts		Percentages	
	Responded	Did Not Respond	Responded	Did Not Respond
Region				
1 Panhandle	17	112	7.0	5.7
2 North Plains	13	63	5.3	3.2
3 North Central	62	399	25.5	20.3
4 Northeast	12	92	4.9	4.7
5 East	9	64	3.7	3.3
6 Southeast	40	415	16.5	21.2
7 Central	40	289	16.5	14.7
8 Southwest	22	280	9.1	14.3
9 West	5	42	2.1	2.1
10 Far West (Mountain)	4	29	1.6	1.5
11 Rio Grande Valley	16	136	6.6	6.9
Unknown	3	41	1.2	2.1

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

- For the DSHS CSHCN sample, the average age of respondents was 14.00 years old and the average age of non-respondents was 14.06 years old ($F=0.027$; $df=1$; 1,688).
- Race/ethnicity was unknown for 16 respondents and 141 non-respondents as these data were missing from the population data file.
- As shown in Table G, statistically significant differences were observed for the age variable ($X^2=28.411$ ***, $df=5$) and the ethnicity variable ($X^2=40.355$ ***, $df=4$).

Table G
Comparison of Response Rates by Demographic Characteristics in Population Data File:
DSHS CSHCN Program (n=1,690)

Demographic Groups	Counts		Percentages	
	Responded	Did Not Respond	Responded	Did Not Respond
Age of youth***				
Under age 2	1	0	0.6	0.0
2 to 4	7	33	4.1	2.2
5 to 7	13	95	7.6	6.3
8 to 12	45	405	26.2	26.7
13 to 17	43	605	25.0	39.9
18 to 21	63	380	36.6	25.0
Gender of youth				
Male	87	830	50.6	54.7
Female	85	688	49.4	45.3

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Demographic Groups	Counts		Percentages	
	Responded	Did Not Respond	Responded	Did Not Respond
Ethnicity of youth***				
White	27	70	15.7	4.6
African American	4	29	2.3	1.9
Hispanic	120	1,261	69.8	83.1
Other	5	17	2.9	1.1
Unknown	16	141	9.3	9.3
Region				
1 Panhandle	8	34	4.7	2.2
2 North Plains	4	21	2.3	1.4
3 North Central	55	469	32.0	30.9
4 Northeast	9	66	5.2	4.3
5 East	3	26	1.7	1.7
6 Southeast	30	292	17.4	19.2
7 Central	7	105	4.1	6.9
8 Southwest	16	141	9.3	9.3
9 West	2	14	1.2	0.9
10 Far West (Mountain)	12	106	7.0	7.0
11 Rio Grande Valley	26	244	15.1	16.1

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

- The average age for HHSC PCS respondents was 12.65 years old and for non-responders the average age was 12.15 years old ($F=1.607$; $df=1$; 2,957).
- Race/ethnicity was unknown for 30 respondents and 331 non-respondents as these data were missing from the population data file. Region was unknown for 1 respondent and 10 non-respondents.
- As shown in Table H, the distribution of demographic characteristics were significantly different between respondents and non-responders in terms of ethnicity ($X^2=48.885$ ***, $df=4$) and region ($X^2=48.061$ ***, $df=11$).

Table H
Comparison of Response Rates by Demographic Characteristics in Population Data File:
HHSC PCS (n=2,959)

Demographic Groups	Counts		Percentages	
	Responded	Did Not Respond	Responded	Did Not Respond
Age of youth				
Under age 2	3	22	1.6	0.8
2 to 4	9	179	4.8	6.5
5 to 7	29	428	15.4	15.4
8 to 12	52	845	27.7	30.5
13 to 17	45	721	23.9	26.0
18 to 21	50	576	26.6	20.8

PART 1 – HHS ENTERPRISE CUSTOMER SATISFACTION SURVEY

Demographic Groups	Counts		Percentages	
	Responded	Did Not Respond	Responded	Did Not Respond
Gender of youth				
Male	107	1,698	56.9	61.3
Female	81	1,073	43.1	38.7
Ethnicity of youth***				
White	33	205	17.6	7.4
African American	24	248	12.8	8.9
Hispanic	95	1,965	50.5	70.9
Other	6	22	3.2	0.8
Unknown	30	331	16.0	11.9
Region***				
1 Panhandle	10	51	5.3	1.8
2 North Plains	4	24	2.1	0.9
3 North Central	22	164	11.7	5.9
4 Northeast	11	125	5.9	4.5
5 East	10	57	5.3	2.1
6 Southeast	28	361	14.9	13.0
7 Central	13	136	6.9	4.9
8 Southwest	22	286	11.7	10.3
9 West	3	41	1.6	1.5
10 Far West (Mountain)	4	96	2.1	3.5
11 Rio Grande Valley	60	1,420	31.9	51.2
Unknown	1	10	0.5	0.4

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

There were several statistically significant differences between respondents and non-respondents. In all agencies, survey results tend to overrepresent white respondents and underrepresent Hispanic respondents. For DARS ECI, the North Central region was overrepresented. Within the DFPS SCS respondents, youth under 2 were overrepresented while ages 13 to 17 and 18 to 21 were underrepresented. For the DSHS CSHCN Program, youth ages 13 to 17 were underrepresented and those 18-21 were overrepresented. Among HHSC PCS respondents, the North Central region was overrepresented and the Rio Grande Valley region was underrepresented. The importance of these over and underrepresentations is minimal because, in all cases, the demographic groups had similar responses to the questions in the survey.

Weighting of Results

The data were weighted so that when analyzing findings within each agency, the data proportion in each age group reflected the proportion in the agency population. When analyzing the findings for the commission as a whole, each agency was given an equal weight, and the age groups within each agency were weighted to reflect their proportions within the agency. Table I shows the sample counts after weighting.¹⁸

¹⁸ Weighted counts are rounded to whole numbers, which introduces rounding error in the reported numbers in groups and therefore in the proportions based on those numbers.

Table I
Weighting of Results

Respondent	Population	Interviews Collected	<u>Weights Within Agency</u>		<u>Weights Across Agencies</u>
			Proportions	Weighted Counts	Weighted Counts ¹⁹
DADS MDCP					
Under age 18	3,867	225	87.6%	230	189
Ages 18-21	547	37	12.4%	32	27
	4,414	262	100.0%	262	216
DARS ECI (only youth on Medicaid)					
Under age 18	35,022	213	100.0%	213	216
Ages 18-21	-	-	-	-	-
		213		213	216
DFPS SCS (only youth with a physical disability)					
Under age 18	12,520	221	89.7%	218	193
Ages 18-21	1,430	22	10.3%	25	22
	13,950	243	100.0%	243	216
DSHS CSHCN Program					
Under age 18	2,153	109	74.0%	127	160
Ages 18-21	756	63	26.0%	45	56
	2,909	172	100.0%	172	216
HHSC PCS					
Under age 18	4,810	138	78.4%	147	169
Ages 18-21	1,325	50	21.6%	41	47
	6,135	188	100.0%	188	216
Total Sample Size					
	62,430	1,078		1,078	1,078

¹⁹ Counts are rounded to 216 responses. The actual weighted counts are 215.60.

Analysis by Demographic Groups

Each question in the survey was cross-tabulated with the following demographic characteristics obtained from agency records:

- youth's race/ethnicity,
- youth's gender, and
- youth's State Health Services Region.

Each question was also cross-tabulated by the following demographic characteristics obtained from the interview:

- youth's age,²⁰
- language of interview (English/Spanish), and
- relationship of survey respondent to the youth.

Whenever the responses to a single question are divided by demographic groups (e.g., responses from males versus responses from females), the responses from one group will rarely exactly match the responses from the other group (or groups); there will often be some difference between the groups. It is important to consider whether these differences between groups in the sample are representative of differences between the same groups within the population the sample represents. SRC tests the statistical significance of all differences between demographic groups, and the text of the report only describes differences that are statistically significant. Therefore, the text of this report only describes differences that are likely to exist in the population.²¹ Unknown/missing ethnicity data were excluded from the analysis by ethnicity, and those with an unknown/missing region were excluded from the analysis by region.

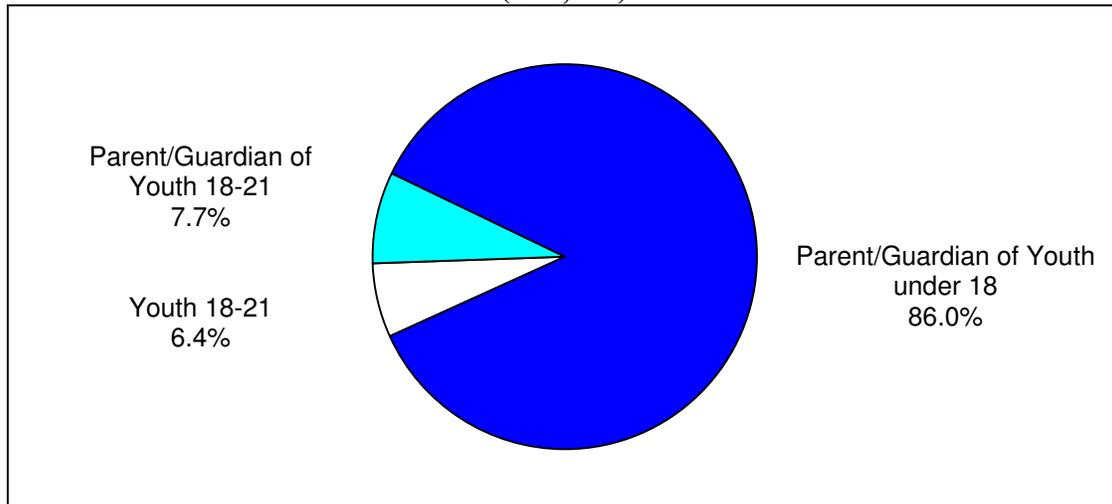
²⁰ Date of birth was available in the population files, but the analyses of survey results use the age obtained by the interviewer to ensure the respondent received the appropriate survey for the youth's age at the time of the survey.

²¹ For all cross-tabulations, a test of significance (Chi-Square) was used to compare responses between groups. Statistically significant differences were indicated with the following symbols: * p >0.05, ** p <0.01, *** p <0.001. If no asterisk is present, the cross-tabulation was not statistically significant and was not discussed in the text.

II. SAMPLE CHARACTERISTICS

All Health and Human Services (HHS) Agencies: Respondent Profile

Figure 1
Person Responding to Survey: All HHS Agencies
(n=1,078)



- Ninety-four percent of survey respondents were parents or guardians of youth under age 18 (86.0 percent) or parents or guardians of youth ages 18 through 21 (7.7 percent) who were unable to take the survey themselves (see Figure 1). Six percent of youth ages 18 through 21 answered the survey themselves. All findings are weighted.
- As shown in Table 1, the youth’s mother (77.2 percent) followed by the youth’s father (8.8 percent) were most likely to complete the interview for youths under age 18.

Table 1
Relationship of Respondent to Youth under Age 18: All HHS Agencies
(n=926)

Relationship	Percentage Responding
Mother (biological, step, foster, adoptive)	77.2
Father (biological, step, foster, adoptive)	8.8
Grandmother	8.0
Grandfather	1.7
Aunt	1.2
Other	3.1

All HHS Agencies: Demographic Characteristics

Table 2
Age and Ethnicity of Youth, and Language of Interview: All HHS Agencies

Demographics	Percentage	
	N	Percentage
Age of youth		
Under age 2	85	7.9
2 to 4	252	23.4
5 to 7	134	12.4
8 to 12	233	21.6
13 to 17	222	20.6
18 to 21	152	14.1
Ethnicity of youth		
Non-Hispanic White or Caucasian	336	31.2
African-American or Black	148	13.8
Hispanic or Latino	467	43.3
Other	39	3.6
Unknown/missing	87	8.1
Language of interview		
English	914	84.8
Spanish	164	15.2

- As shown in Table 2, 43.7 percent of youth were under age 8. Forty-two percent were ages 8 to 17. Fourteen percent were youth ages 18 to 21.
- Forty-three percent of youth were Hispanic or Latino. Thirty-one percent of youth were Non-Hispanic White or Caucasian. Fourteen percent were African-American or Black. Asian and Other categories were combined into the Other category. They comprised 11.7 percent of the sample. Respondents with unknown or missing ethnicity were classified as missing data in the cross-tabulations.
- Eighty-five percent of the interviews were conducted in English with 15.2 percent conducted in Spanish.

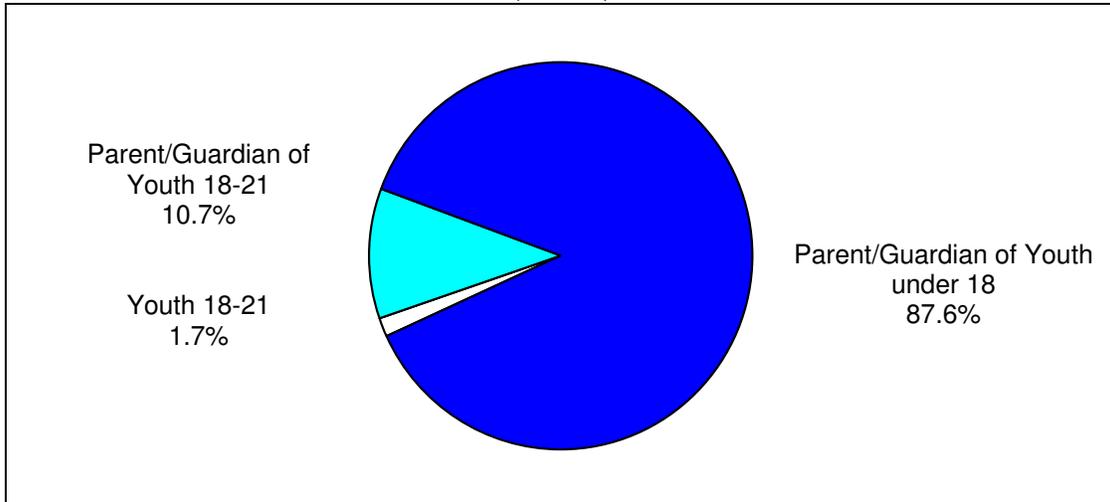
Table 3
Gender of Youth and Region of Residence: All HHS Agencies

Demographics	Percentage	
	N	Percentage
Gender of youth		
Male	607	56.3
Female	471	43.7
Region		
1 Panhandle	53	4.9
2 North Plains	37	3.5
3 North Central	267	24.8
4 Northeast	53	4.9
5 East	43	4.0
6 Southeast	171	15.9
7 Central	90	8.3
8 Southwest	133	12.4
9 West	23	2.2
10 Far West (Mountain)	45	4.2
11 Rio Grande Valley	141	13.1
99 Unknown	21	2.0

- Fifty-six percent of the youth were male while 43.7 percent were female.
- The largest percentage of youth lived in region 3 North Central (24.8 percent). This was followed by region 6 Southeast (15.9 percent) and region 11 Rio Grande Valley (13.1 percent). Youth with an unknown region were classified as missing data in the cross-tabulations.

Texas Department of Aging and Disability Services (DADS): Respondent Profile

Figure 2
Person Responding to Survey: DADS MDCP
(n=262)



- Ninety-eight percent of survey respondents were parents or guardians of youth under age 18 (87.6 percent) or parents or guardians of youth ages 18 through 21 (10.7 percent) who were unable to take the survey themselves (see Figure 2). Two percent of youth ages 18 through 21 answered for themselves. All findings are weighted.
- As shown in Table 4, the youth’s mother (77.3 percent) followed by the youth’s father (14.2 percent) were most likely to complete the interview for youths under age 18.

Table 4
Relationship of Respondent to Youth under Age 18: DADS MDCP
(n=230)

Relationship	Percentage Responding
Mother (biological, step, foster, adoptive)	77.3
Father (biological, step, foster, adoptive)	14.2
Grandmother	5.8
Grandfather	0.9
Aunt	0.4
Other	1.3

DADS: Demographic Characteristics

Table 5
Age and Ethnicity of Youth, and Language of Interview: DADS MDCP

Demographics	Percentage	
	N	Percentage
Age of youth		
Under age 2	2	0.8
2 to 4	24	9.3
5 to 7	55	21.0
8 to 12	81	30.8
13 to 17	67	24.7
18 to 21	32	12.4
Ethnicity of youth		
Non-Hispanic White or Caucasian	135	51.4
African-American or Black	18	6.8
Hispanic or Latino	60	23.0
Other	4	3.4
Unknown/missing	40	15.3
Language of interview		
English	259	98.9
Spanish	3	1.1

- As shown in Table 5, nearly one-third (31.1 percent) of youth were under age 8. Fifty-six percent were ages 8 to 17. Twelve percent were youth ages 18 to 21.
- Approximately half (51.4 percent) of the youths were Non-Hispanic White or Caucasian. Nearly one-quarter (23.0 percent) were Hispanic or Latino. Seven percent were African-American or Black. Asian and Other categories were combined into Other. They comprised 18.7 percent of the sample. Youth with unknown or missing ethnicity were classified as missing data in the cross-tabulations.
- Ninety-nine percent of the interviews were conducted in English with 1 percent conducted in Spanish.

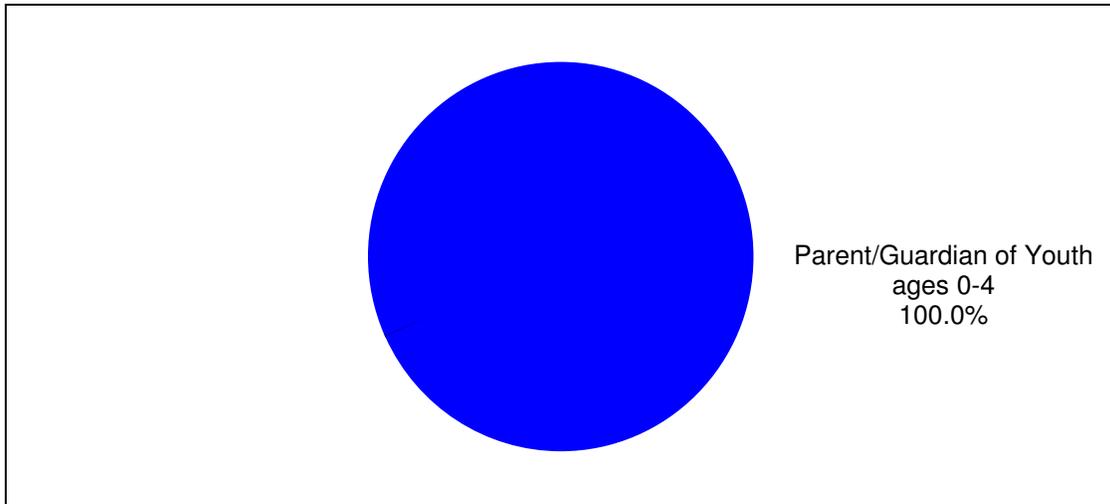
Table 6
Gender of Youth and Region of Residence: DADS MDCP

Demographics	Percentage	
	N	Percentage
Gender of youth		
Male	161	61.3
Female	101	38.7
Region		
1 Panhandle	8	3.1
2 North Plains	9	3.3
3 North Central	79	30.1
4 Northeast	12	4.6
5 East	4	1.6
6 Southeast	35	13.5
7 Central	15	5.7
8 Southwest	50	18.9
9 West	8	3.1
10 Far West (Mountain)	4	1.5
11 Rio Grande Valley	17	6.3
99 Unknown	22	8.2

- Fifty-seven percent of the youth were male while 43.1 percent were female.
- The largest percentage of youth lived in region 3 North Central (30.1 percent). This was followed by region 8 Southwest (18.9 percent) and region 6 Southeast (13.5 percent). Youth with an unknown region were classified as missing data in the cross-tabulations.

Department of Assistive and Rehabilitative Services (DARS): Respondent Profile

Figure 3
Person Responding to Survey: DARS ECI Youth on Medicaid
(n=213)



- One-hundred percent of survey respondents were parents or guardians of youth through age 4.²² All findings are weighted.
- As shown in Table 7, the youth’s mother (79.3 percent) followed by the youth’s grandmother (10.3 percent) were most likely to complete the interview for youths under age 18.

Table 7
Relationship of Respondent to Youth under Age 18: DARS ECI Youth on Medicaid
(n=213)

Relationship	Percentage Responding
Mother (biological, step, foster, adoptive)	79.3
Grandmother	10.3
Father (biological, step, foster, adoptive)	6.1
Grandfather	2.3
Aunt	1.4
Other	0.5

²² DARS ECI program serves children up to the age of three, but because of the way the sample was drawn, some children may have been older than three years of age at the time of the survey.

DARS: Demographic Characteristics

Table 8
Age and Ethnicity of Youth, and Language of Interview: DARS ECI Youth on Medicaid

Demographics	Percentage	
	N	Percentage
Age of youth		
Under age 2	48	22.5
2 to 4 ²³	165	77.5
Ethnicity of youth		
Non-Hispanic White or Caucasian	70	32.9
African-American or Black	33	15.5
Hispanic or Latino	102	47.9
Other	8	3.8
Unknown/missing	0	0.0
Language of interview		
English	187	87.8
Spanish	26	12.2

- As shown in Table 8, 22.5 percent of youth were parents under age 2. Seventy-eight percent were ages 2 to 4.
- Approximately one-third (32.9 percent) of the youth were Non-Hispanic White or Caucasian. Nearly half (47.9 percent) were Hispanic or Latino. Sixteen percent were African-American or Black. Asian and Other categories were combined into Other. They comprised 3.8 percent of the sample.
- Eighty-eight percent of the interviews were conducted in English with 12.2 percent conducted in Spanish.

²³ DARS ECI program serves children up to the age of three, but because of the way the sample was drawn, some children may have been older than three years of age at the time of the survey.

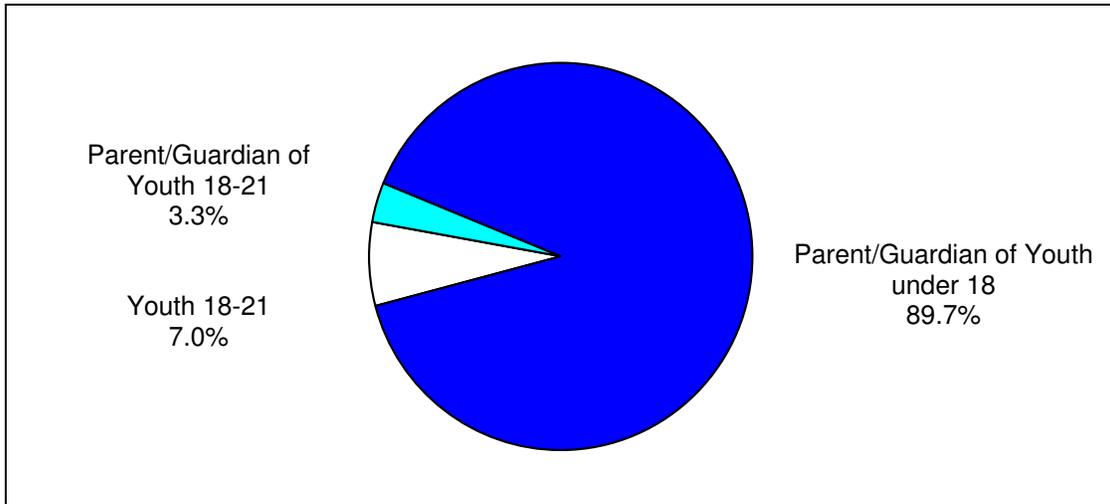
Table 9
Gender of Youth and Region of Residence: DARS ECI Youth on Medicaid

Demographics	Percentage	
	N	Percentage
Gender of youth		
Male	126	59.2
Female	87	40.8
Region		
1 Panhandle	8	3.8
2 North Plains	8	3.8
3 North Central	54	25.4
4 Northeast	9	4.2
5 East	16	7.5
6 Southeast	38	17.8
7 Central	19	8.9
8 Southwest	26	12.2
9 West	6	2.8
10 Far West (Mountain)	17	8.0
11 Rio Grande Valley	12	5.6
99 Unknown	0	0.0

- Fifty-nine percent of the youth were male while 41 percent were female (see Table 9).
- The largest percentage of youth lived in region 3 North Central (25.4 percent). This was followed by region 6 Southeast (17.8 percent) and region 8 Southwest (12.2 percent).

Department of Family and Protective Services (DFPS): Respondent Profile

Figure 4
Person Responding to Survey:
DFPS SCS Youth with a Physical Disability
(n=243)



- Ninety-three percent of survey respondents were parents or guardians of youth under age 18 (89.7 percent) or parents or guardians of youth ages 18 through 21 (3.3 percent) who were unable to take the survey themselves (see Figure 4). Seven percent of youth ages 18 through 21 answered for themselves. All findings are weighted.
- As shown in Table 10, the youth’s mother (65.0 percent) followed by the youth’s father (13.6 percent) were most likely to complete the interview for youths under age 18.

Table 10
Relationship of Respondent to Youth under Age 18:
DFPS SCS Youth with a Physical Disability
(n=217)²⁴

Relationship	Percentage Responding
Mother (biological, step, foster, adoptive)	65.0
Father (biological, step, foster, adoptive)	13.6
Grandmother	10.0
Grandfather	0.9
Aunt	0.9
Other	9.6

²⁴ A total of 217 respondents, or 99.5 percent of all respondents, answered this question. Of the remaining respondents, 0.0 percent answered "don't know" and 0.5 percent refused to answer.

DFPS: Demographic Characteristics

Table 11
Age and Ethnicity of Youth, and Language of Interview:
DFPS SCS Youth with a Physical Disability

Demographics	Percentage	
	N	Percentage
Age of youth		
Under age 2	34	13.8
2 to 4	50	20.7
5 to 7	36	15.0
8 to 12	43	17.9
13 to 17	53	21.9
18 to 21 ²⁵	26	10.7
Ethnicity of youth		
Non-Hispanic White or Caucasian	93	38.2
African-American or Black	76	31.2
Hispanic or Latino	64	26.5
Other	10	4.1
Unknown/missing	0	0.0
Language of interview		
English	239	98.3
Spanish	4	1.7

- As shown in Table 11, 49.5 percent of youth were parents or guardians of youth under age 8. Forty percent were youth ages 8 to 17. Eleven percent were youth ages 18 to 21.
- Thirty-eight percent of the youth were Non-Hispanic White or Caucasian. Thirty-one percent were African-American or Black. Approximately one-fourth (26.5 percent) were Hispanic or Latino. Asian and Other categories were combined into Other. They comprised 4.1 percent of the sample.
- Ninety-eight percent of the interviews were conducted in English with 1.7 percent conducted in Spanish.

²⁵ There was a discrepancy in the age of a youth in the 18 to 21 category. The age gathered during the interview was 18. However, the population file lists this youth as age 9. Because there is no way to be tell how old the youth really was at the time of the interview, the count is left as 26 rather than 25 in this table.

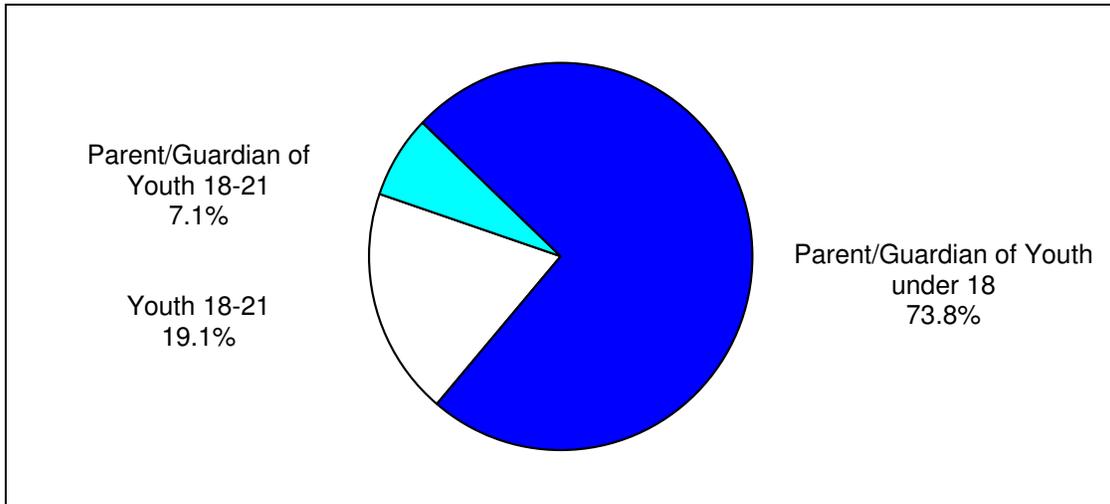
Table 12
Gender of Youth and Region of Residence:
DFPS SCS Youth with a Physical Disability

Demographics	Percentage	
	N	Percentage
Gender of youth		
Male	131	53.8
Female	112	46.2
Region		
1 Panhandle	17	7.1
2 North Plains	13	5.4
3 North Central	62	25.4
4 Northeast	12	4.9
5 East	9	3.7
6 Southeast	40	16.3
7 Central	40	16.5
8 Southwest	22	9.2
9 West	5	2.0
10 Far West (Mountain)	4	1.7
11 Rio Grande Valley	16	6.6
99 Unknown	3	1.3

- Fifty-four percent of the youth were male while 46.2 percent were female (see Table 12).
- The largest percentage of youth lived in region 3 North Central (25.4 percent). This was followed by region 7 Central (16.5 percent) and region 6 Southeast (16.3 percent). Youth with an unknown region were classified as missing data in the cross-tabulations.

Department of State Health Services (DSHS): Respondent Profile

Figure 5
Person Responding to Survey:
DSHS CSHCN Program
(n=172)



- Eighty-one percent of survey respondents were parents or guardians of youth under age 18 or parents (73.8 percent) or guardians of youth ages 18 through 21 (7.1 percent) who were unable to take the survey themselves (see Figure 5). Nineteen percent of youth ages 18 through 21 answered for themselves. All findings are weighted.
- As shown in Table 13, the youth’s mother (87.2 percent) followed by the youth’s father (6.4 percent) were most likely to complete the interview for youths under age 18.

Table 13
Relationship of Respondent to Youth under Age 18:
DSHS CSHCN Program
(n=127)

Relationship	Percentage Responding
Mother (biological, step, foster, adoptive)	87.2
Father (biological, step, foster, adoptive)	6.4
Grandmother	2.8
Grandfather	0.9
Aunt	0.9
Other	1.8

DSHS: Demographic Characteristics

Table 14
Age and Ethnicity of Youth, and Language of Interview:
DSHS CSHCN Program

Demographics	Percentage	
	N	Percentage
Age of youth		
Under age 2	1	0.7
2 to 4	8	4.7
5 to 7	15	8.8
8 to 12	51	29.8
13 to 17	51	29.8
18 to 21	45	26.2
Ethnicity of youth		
Non-Hispanic White or Caucasian	28	16.2
African-American or Black	5	2.7
Hispanic or Latino	118	68.4
Other	6	3.3
Unknown/missing	16	9.4
Language of interview		
English	92	53.5
Spanish	80	46.5

- As shown in Table 14, 14.2 percent of youth were under age 8. Sixty percent were ages 8 to 17. Twenty-six percent were youth ages 18 to 21.
- Over two-thirds (68.4 percent) of the youth were Hispanic or Latino. Sixteen percent were Non-Hispanic White or Caucasian. Three percent were African-American or Black. Asian and Other categories were combined into Other. They comprised 12.7 percent of the sample. Youth with unknown or missing ethnicity were classified as missing data in the cross-tabulations.
- Fifty-four percent of the interviews were conducted in English with 46.5 percent conducted in Spanish.

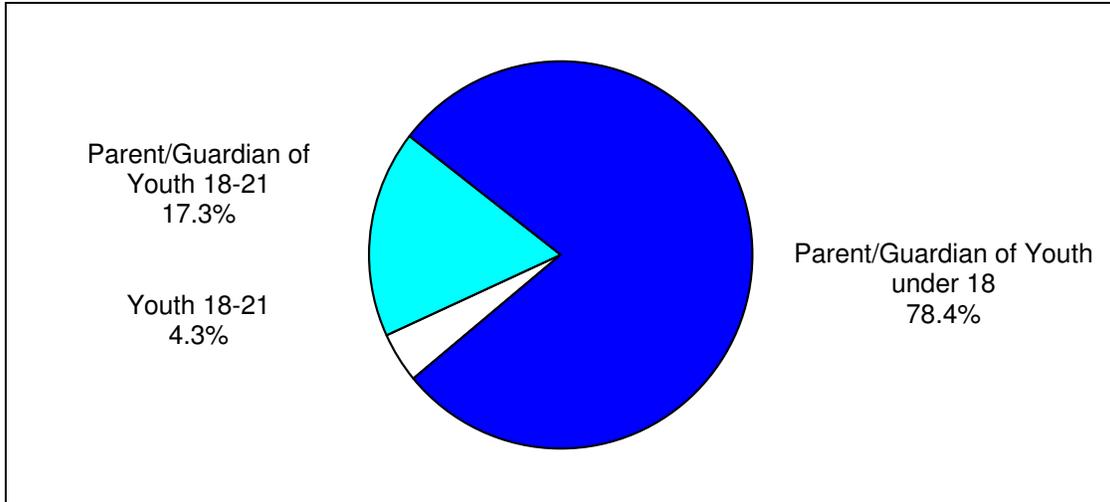
Table 15
Gender of Youth and Region of Residence:
DSHS CSHCN Program

Demographics	Percentage	
	N	Percentage
Gender of youth		
Male	87	50.5
Female	85	49.5
Region		
1 Panhandle	8	4.9
2 North Plains	5	2.7
3 North Central	54	31.5
4 Northeast	8	4.8
5 East	3	1.5
6 Southeast	30	17.2
7 Central	6	3.7
8 Southwest	16	9.5
9 West	2	1.4
10 Far West (Mountain)	13	7.6
11 Rio Grande Valley	26	15.3
99 Unknown	0	0.0

- Fifty-one percent of the youth were male while 49.5 percent were female (see Table 15).
- The largest percentage of youth lived in region 3 North Central (31.5 percent). This was followed by region 6 Southeast (17.2 percent) and region 11 Rio Grande Valley (15.3 percent).

Health and Human Services Commission (HHSC): Respondent Profile

Figure 6
Person Responding to Survey: HHSC PCS
(n=188)



- Ninety-six percent of survey respondents were parents or guardians of youth under age 18 or parents (78.4 percent) or guardians of youth ages 18 through 21 (17.3 percent) who were unable to take the survey themselves (see Figure 6). Four percent of youth ages 18 through 21 answered for themselves. All findings are weighted.
- As shown in Table 16, the youth’s mother (79.0 percent) followed by the youth’s grandmother (10.0 percent) were most likely to complete the interview for youths under age 18.

Table 16
Relationship of Respondent to Youth under Age 18: HHSC PCS
(n=147)

Relationship	Percentage Responding
Mother (biological, step, foster, adoptive)	79.0
Grandmother	10.0
Grandfather	3.6
Father (biological, step, foster, adoptive)	2.9
Aunt	2.2
Other	2.2

HHSC: Demographic Characteristics

Table 17
Age and Ethnicity of Youth, and Language of Interview: HHSC PCS

Demographics	Percentage	
	N	Percentage
Age of youth		
Under age 2	3	1.7
2 to 4	9	4.5
5 to 7	32	17.0
8 to 12	56	29.5
13 to 17	48	25.6
18 to 21	41	21.6
Ethnicity of youth		
Non-Hispanic White or Caucasian	33	17.4
African-American or Black	24	12.7
Hispanic or Latino	96	50.8
Other	6	3.4
Unknown/missing	29	15.7
Language of interview		
English	160	85.3
Spanish	28	14.7

- As shown in Table 17, 23.2 percent of youth were under age 8. Fifty-five percent were ages 8 to 17. Twenty-two percent were youth ages 18 to 21.
- One-half (50.8 percent) of youth were Hispanic or Latino. Seventeen percent of the youth were Non-Hispanic White or Caucasian. Thirteen percent were African-American or Black. Asian and Other categories were combined into Other. They comprised 19.1 percent of the sample. Youth with unknown or missing ethnicity were classified as missing data in the cross-tabulations.
- Eighty-five percent of the interviews were conducted in English with 14.7 percent conducted in Spanish.

Table 18
Gender of Youth and Region of Residence: HHSC PCS

Demographics	Percentage	
	N	Percentage
Gender of youth		
Male	107	57.0
Female	81	43.0
Region		
1 Panhandle	10	5.5
2 North Plains	4	2.1
3 North Central	22	11.7
4 Northeast	11	6.0
5 East	10	5.5
6 Southeast	28	14.7
7 Central	13	6.8
8 Southwest	22	12.0
9 West	3	1.6
10 Far West (Mountain)	4	2.1
11 Rio Grande Valley	59	31.5
99 Unknown	1	0.4

- Fifty-seven percent of the youth were male while 43.0 percent were female (see Table 18).
- The largest percentage of youth lived in region 11 Rio Grande Valley (31.5 percent). This was followed by region 6 Southeast (14.7 percent) and region 8 Southwest (12.0 percent). Youth with an unknown region were labeled as missing data in the cross-tabulations.

III. FINDINGS: ALL HHS AGENCIES

The combined findings for all five customer groups participating in the survey are reported in this section to reflect the combined results of customers' experiences at each agency. These combined results do not represent customer satisfaction across the HHS system for the following reasons:

- Respondents were asked about their satisfaction with the specific agency program provided by DADS, DARS, DFPS, DSHS or HHSC and not with the HHS system.
- Each agency's customers have an equal weight in the summary statistics, regardless of the number of customers in the CSHCN program included for that agency.
- The survey was limited to enrollees in specific programs for CSHCN. The survey did not include all HHS programs that serve CSHCN.

All respondents were asked three questions about customer satisfaction: overall satisfaction with the benefits or services received from the agency, the difficulty customers had in getting needed benefits or services, and the length of time customers waited to receive benefits or services. A summary of their responses is presented in Table 19. More detailed analysis is provided by agency in the section that follows.

Table 19
Satisfaction with HHS Agencies Combined

	Percentage responding			
	Agree	Somewhat agree	Somewhat disagree	Disagree
It wasn't difficult/It was easy to get the benefits or services needed from (program name) under (agency name). (n=1,051) ²⁶	64.8	15.2	7.4	12.6
The length of time waited to receive benefits or services from (program name) under (agency name) was reasonable. (n=1,049) ²⁷	67.3	13.8	5.7	13.2
Overall, I am/youth is satisfied with the benefits or services received from (program name) under (agency name). (n=1,055) ²⁸	81.5	11.7	2.8	4.0

- All respondents were asked to rate their satisfaction with several elements of their experience with an HHS agency. The combined results shown in Table 19 reflect the satisfaction of the agency populations included in the survey and not the HHS system as a whole.

Not difficult/Easy to get benefits or services

- Eighty percent of all respondents indicated that they either agreed (64.8 percent) or somewhat agreed (15.2 percent) with the statement, “It wasn’t difficult/It was easy to get the benefits or services needed from the (program name) under (agency name).”

²⁶ The wording of this question was slightly different for two age groups. The parent or guardian of youth under age 18 answered the question, “It wasn’t difficult to get the benefits or services needed.” Youth ages 18-21 or their parent or guardian answered the question, “It was easy to get the benefits or services needed.” For Spanish-speaking youth age 18 to 21, this question read “It was difficult to get the benefits or services needed.” The answers for Spanish-speaking youth age 18 to 21 were recoded from agree to disagree, somewhat agree to somewhat disagree, somewhat disagree to somewhat agree, and disagree to agree to be consistent with the language used for other respondents. A total of 1,051 respondents, or 97.5 percent of all respondents, answered this question. Of the remaining respondents, 2.3 percent answered "don't know" and 0.2 percent refused to answer.

²⁷ A total of 1,049 respondents, or 97.3 percent of all respondents, answered this question. Of the remaining respondents, 2.4 percent answered "don't know" and 0.3 percent refused to answer.

²⁸ A total of 1,055 respondents, or 97.9 percent of all respondents, answered this question. Of the remaining respondents, 1.8 percent answered "don't know" and 0.3 percent refused to answer.

Length of time waited to receive benefits or services was reasonable

- Eighty-one percent of all respondents reported they either agreed (67.3 percent) or somewhat agreed (13.8 percent) that the length of time they waited to receive benefits or services from the agency was reasonable.

Overall satisfaction with benefits or services received

- Ninety-three percent of all respondents indicated they either agreed (81.5 percent) or somewhat agreed (11.7 percent) that they were satisfied overall with the benefits or services they received from the agency.

IV. FINDINGS: INDIVIDUAL HHS AGENCIES

Findings for each of the five individual HHS agencies (DADS, DARS, DFPS, DSHS, and HHSC) are reported in this section. These results do not represent customer satisfaction for all customers of an agency. The survey was limited to participants in programs for children with special health care needs. Also, the survey did not necessarily include all of the agency's programs that serve children with special health care needs.

All respondents were asked three questions about customer satisfaction: overall satisfaction with the benefits or services received from the agency, the difficulty customers had in getting needed benefits or services, and the length of time customers waited to receive benefits or services.

Texas Department of Aging and Disability Services (DADS)

Table 20
Satisfaction with Medically Dependent Children Program under Texas DADS

	Percentage responding			
	Agree	Somewhat agree	Somewhat disagree	Disagree
It wasn't difficult/It was easy for me to get the benefits or services needed from the Medically Dependent Children Program under the Texas Department of Aging and Disability Services (DADS). (n=255) ²⁹	42.4	21.7	14.2	21.7
The length of time waited to receive benefits or services from the Medically Dependent Children Program under the Texas Department of Aging and Disability Services (DADS) was reasonable. (n=251) ³⁰	35.0	16.8	11.7	36.5
Overall, I/youth is satisfied with the benefits or services received from the Medically Dependent Children Program under the Texas Department of Aging and Disability Services (DADS). (n=257) ³¹	79.3	16.9	2.3	1.5

²⁹ The wording of this question was slightly different for two age groups. The parent or guardian of youth under age 18 answered the question, "It wasn't difficult to get the benefits or services needed." Youth ages 18-21 or their parent or guardian answered the question, "It was easy to get the benefits or services needed." For Spanish-speaking youth age 18 to 21, this question read "It was difficult to get the benefits or services needed." The answers for Spanish-speaking youth age 18 to 21 were recoded from agree to disagree, somewhat agree to somewhat disagree, somewhat disagree to somewhat agree, and disagree to agree to be consistent with the language used for other respondents. A total of 255 respondents, or 97.5 percent of all respondents, answered this question. Of the remaining respondents, 2.5 percent answered "don't know" and 0.0 percent refused to answer.

³⁰ A total of 251 respondents, or 95.7 percent of all respondents, answered this question. Of the remaining respondents, 4.3 percent answered "don't know" and 0.0 percent refused to answer.

³¹ A total of 257 respondents, or 98.3 percent of all respondents, answered this question. Of the remaining respondents, 1.7 percent answered "don't know" and 0.0 percent refused to answer.

Not difficult/Easy to get benefits or services

- Sixty-four percent of DADS MDCP respondents indicated that they either agreed (42.4 percent) or somewhat agreed (21.7 percent) with the statement, “It wasn’t difficult/It was easy to get the benefits or services needed from the Medically Dependent Children Program under the Texas Department of Aging and Disability Services (DADS).” (see Table 20).
- The percentage of youth who agreed or somewhat agreed that it wasn’t difficult/it was easy to get benefits or services needed from DADS MDCP varied with the age of the youth and was higher among youth 2 to 4. None of the other cross-tabulations was statistically significant (see Table 21).

**Table 21
Not Difficult/Easy to Get Benefits or Services from DADS MDCP
by Selected Demographics**

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth**					
Under age 2	2	50.0	0.0	0.0	50.0
2 to 4	24	70.8	4.2	20.8	4.2
5 to 7	55	54.5	9.1	10.9	25.5
8 to 12	77	31.2	31.2	18.2	19.5
13 to 17	65	36.9	21.5	10.8	30.8
18 to 21	30	36.7	36.7	13.3	13.3
Gender of youth					
Male	156	43.6	19.2	13.5	23.7
Female	99	40.4	26.3	15.2	18.2
Ethnicity of youth					
White	130	33.1	25.4	14.6	26.9
African-American/Black	18	44.4	22.2	5.6	27.8
Hispanic	60	51.7	18.3	15.0	15.0
Other	9	55.6	11.1	22.2	11.1
Region					
1 Panhandle	8	37.5	37.5	25.0	0.0
2 North Plains	9	44.4	44.4	11.1	0.0
3 North Central	77	42.9	16.9	18.2	22.1
4 Northeast	12	25.0	41.7	0.0	33.3
5 East	4	25.0	50.0	25.0	0.0
6 Southeast	35	42.9	20.0	11.4	25.7
7 Central	15	46.7	20.0	6.7	26.7
8 Southwest	47	34.0	23.4	21.3	21.3
9 West	8	62.5	0.0	0.0	37.5
10 Far West (Mountain)	3	0.0	33.3	33.3	33.3
11 Rio Grande Valley	17	64.7	11.8	0.0	23.5

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Language of interview					
English	252	42.9	21.8	14.3	21.0
Spanish	3	0.0	0.0	0.0	100.0

Length of time waited to receive benefits or services was reasonable

- Over half (51.8 percent) of DADS MDCP respondents reported they either agreed (35.0 percent) or somewhat agreed (16.8 percent) that the length of time they waited to receive benefits or services from the agency was reasonable.
- None of the cross-tabulations regarding the reasonableness of the time waited to receive benefits or services were statistically significant. However, the responses of DADS MDCP respondents broken down by demographic groups are shown in Table 22.

Table 22

Length of Time Waited to Receive DADS MDCP Benefits or Services Was Reasonable by Selected Demographics

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	2	50.0	0.0	50.0	0.0
2 to 4	23	60.9	8.7	17.4	13.0
5 to 7	55	36.4	10.9	5.5	47.3
8 to 12	78	25.6	25.6	11.5	37.2
13 to 17	65	29.2	13.8	15.4	41.5
18 to 21	26	46.2	15.4	7.7	30.8
Gender of youth					
Male	153	34.0	17.6	10.5	37.9
Female	96	36.5	15.6	13.5	34.4
Ethnicity of youth					
White	129	25.6	20.2	12.4	41.9
African-American/Black	18	50.0	5.6	16.7	27.8
Hispanic	58	39.7	13.8	10.3	36.2
Other	9	66.7	22.2	11.1	0.0

PART 1 – HHS ENTERPRISE CUSTOMER SATISFACTION SURVEY

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Region					
1 Panhandle	8	50.0	25.0	0.0	25.0
2 North Plains	9	66.7	22.2	0.0	11.1
3 North Central	76	34.2	21.1	13.2	31.6
4 Northeast	11	27.3	27.3	18.2	27.3
5 East	4	25.0	0.0	25.0	50.0
6 Southeast	33	27.3	21.2	15.2	36.4
7 Central	15	26.7	26.7	13.3	33.3
8 Southwest	47	38.2	4.3	10.6	46.8
9 West	8	50.0	12.5	0.0	37.5
10 Far West (Mountain)	3	0.0	33.3	0.0	66.7
11 Rio Grande Valley	17	29.4	11.8	11.8	47.1
Language of interview					
English	248	35.1	16.9	11.7	36.3
Spanish	3	33.3	0.0	0.0	66.7

Overall satisfaction with benefits or services received

- Ninety-six percent of DADS MDCP respondents indicated they either agreed (79.3 percent) or somewhat agreed (16.9 percent) that they were satisfied overall with the benefits or services they received from the agency.
- While none of the cross-tabulations about overall satisfaction with benefits or services received from DADS MDCP were statistically significant, the responses of DADS MDCP respondents broken down by demographic groups are shown in Table 23.

**Table 23
Overall Satisfaction with Benefits or Services Received from DADS MDCP
by Selected Demographics**

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	2	100.0	0.0	0.0	0.0
2 to 4	24	87.5	12.5	0.0	0.0
5 to 7	55	80.0	14.5	3.6	1.8
8 to 12	79	74.7	20.3	3.8	1.3
13 to 17	67	88.1	11.9	0.0	0.0
18 to 21	29	62.1	27.6	3.4	6.9
Gender of youth					
Male	158	81.6	15.2	1.3	1.9
Female	100	75.0	20.0	4.0	1.0

PART 1 – HHS ENTERPRISE CUSTOMER SATISFACTION SURVEY

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Ethnicity of youth					
White	132	74.2	20.5	3.8	1.5
African-American/Black	18	88.9	11.1	0.0	0.0
Hispanic	61	78.7	18.0	1.6	1.6
Other	9	77.8	22.2	0.0	0.0
Region					
1 Panhandle	8	62.5	37.5	0.0	0.0
2 North Plains	9	100.0	0.0	0.0	0.0
3 North Central	78	79.5	17.9	1.3	1.3
4 Northeast	11	72.7	27.3	0.0	0.0
5 East	4	50.0	50.0	0.0	0.0
6 Southeast	35	80.0	17.1	0.0	2.9
7 Central	15	80.0	13.3	0.0	6.7
8 Southwest	49	79.6	14.3	6.1	0.0
9 West	8	87.5	0.0	12.5	0.0
10 Far West (Mountain)	3	66.7	33.3	0.0	0.0
11 Rio Grande Valley	17	76.5	17.6	0.0	5.9
Language of interview					
English	225	78.8	17.3	2.4	1.6
Spanish	3	100.0	0.0	0.0	0.0

Department of Assistive and Rehabilitative Services (DARS)

Table 24
Satisfaction with Early Childhood Intervention Services Program under Texas DARS:
Youth on Medicaid

	Percentage responding			
	Agree	Somewhat agree	Somewhat disagree	Disagree
It wasn't difficult/It was easy for me to get the benefits or services needed from the Early Childhood Intervention Services Program under the Texas Department of Assistive and Rehabilitative Services (DARS). (n=208) ³²	81.7	7.2	3.4	7.7
The length of time waited to receive benefits or services from the Early Childhood Intervention Services Program under the Texas Department of Assistive and Rehabilitative Services (DARS) was reasonable. (n=211) ³³	84.4	10.4	0.5	4.7
Overall, I/youth is satisfied with the benefits or services received from the Early Childhood Intervention Services Program under the Texas Department of Assistive and Rehabilitative Services (DARS). (n=207) ³⁴	85.0	9.2	2.4	3.4

³² The wording of this question was slightly different for two age groups. The parent or guardian of youth under age 18 answered the question, "It wasn't difficult to get the benefits or services needed." Youth ages 18-21 or their parent or guardian answered the question, "It was easy to get the benefits or services needed." A total of 208 respondents, or 97.7 percent of all respondents, answered this question. Of the remaining respondents, 1.9 percent answered "don't know" and 0.5 percent refused to answer the question.

³³ A total of 211 respondents, or 99.1 percent of all respondents, answered this question. Of the remaining respondents, 0.5 percent answered "don't know" and 0.5 percent refused to answer the question.

³⁴ A total of 207 respondents, or 97.2 percent of all respondents, answered this question. Of the remaining respondents, 2.3 percent answered "don't know" and 0.5 percent refused to answer the question.

Not difficult/Easy to get benefits or services

- As shown in Table 24, 88.9 percent of DARS ECI respondents indicated that they either agreed (81.7 percent) or somewhat agreed (7.2 percent) with the statement, “It wasn’t difficult/It was easy to get the benefits or services needed from the Early Childhood Intervention Services Program under the Texas Department of Assistive and Rehabilitative Services (DARS).”
- None of the cross-tabulations regarding the ease of getting benefits or services from DARS ECI were statistically significant. However, the responses of DARS ECI respondents broken down by demographic groups are shown in Table 25.

**Table 25
Not Difficult/Easy to Get Benefits or Services from DARS ECI
by Selected Demographics**

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	47	83.0	8.5	2.1	6.4
2 to 4	161	81.4	6.8	3.7	8.1
Gender of youth					
Male	123	81.3	6.5	4.9	7.3
Female	85	82.4	8.2	1.2	8.2
Ethnicity of youth					
White	68	76.5	7.4	5.9	10.3
African-American/Black	32	84.4	6.3	3.1	6.3
Hispanic	100	85.0	8.0	2.0	5.0
Other	8	75.0	0.0	0.0	25.0
Region					
1 Panhandle	7	85.7	0.0	14.3	0.0
2 North Plains	8	87.5	0.0	0.0	12.5
3 North Central	53	88.7	5.7	3.8	1.9
4 Northeast	9	77.8	0.0	0.0	22.2
5 East	15	73.3	6.7	0.0	20.0
6 Southeast	38	78.9	10.5	2.6	7.9
7 Central	18	94.4	0.0	0.0	5.6
8 Southwest	25	64.0	16.0	8.0	12.0
9 West	6	83.3	0.0	0.0	16.7
10 Far West (Mountain)	17	88.2	11.8	0.0	0.0
11 Rio Grande Valley	12	75.0	8.3	8.3	8.3
Language of interview					
English	182	80.2	7.1	3.8	8.8
Spanish	26	92.3	7.7	0.0	0.0

Length of time waited to receive benefits or services was reasonable

- Ninety-five percent of DARS ECI respondents reported they either agreed (84.4 percent) or somewhat agreed (10.4 percent) that the length of time they waited to receive benefits or services from the agency was reasonable.
- While none of the cross-tabulations about the reasonableness of time waited to receive benefits or services from DARS ECI were statistically significant, the responses of DARS ECI respondents broken down by demographic groups are shown in Table 26.

Table 26
Length of Time Waited to Receive DARS ECI Benefits or Services Was Reasonable
by Selected Demographics

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	47	83.0	12.8	0.0	4.3
2 to 4	164	84.8	9.8	0.6	4.9
Gender of youth					
Male	125	81.6	12.0	0.0	6.4
Female	86	88.4	8.1	1.2	2.3
Ethnicity of youth					
White	69	78.3	15.9	1.4	4.3
African-American/Black	32	90.6	0.0	0.0	9.4
Hispanic	102	87.3	9.8	0.0	2.9
Other	8	75.0	12.5	0.0	12.5
Region					
1 Panhandle	7	85.7	0.0	0.0	14.3
2 North Plains	8	62.5	12.5	12.5	12.5
3 North Central	53	84.9	11.3	0.0	3.8
4 Northeast	9	88.9	0.0	0.0	11.1
5 East	16	81.3	6.3	0.0	12.5
6 Southeast	38	89.5	5.3	0.0	5.3
7 Central	19	94.7	0.0	0.0	5.3
8 Southwest	26	84.6	15.4	0.0	0.0
9 West	6	83.3	16.7	0.0	0.0
10 Far West (Mountain)	17	70.6	29.4	0.0	0.0
11 Rio Grande Valley	12	83.3	16.7	0.0	0.0
Language of interview					
English	185	83.2	10.8	0.5	5.4
Spanish	26	92.3	7.7	0.0	0.0

Overall satisfaction with benefits or services received

- Ninety-four percent of DARS ECI respondents indicated they either agreed (85.0 percent) or somewhat agreed (9.2 percent) that they were satisfied overall with the benefits or services they received from the agency.
- While none of the cross-tabulations about overall satisfaction with benefits or services received from DARS ECI were statistically significant, the responses of DARS ECI respondents broken down by demographic groups are shown in Table 27.

**Table 27
Overall Satisfaction with Benefits or Services Received from DARS ECI
by Selected Demographics**

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	44	86.4	6.8	2.3	4.5
2 to 4	163	84.7	9.8	2.5	3.1
Gender of youth					
Male	122	81.1	11.5	3.3	4.1
Female	85	90.6	5.9	1.2	2.4
Ethnicity of youth					
White	69	76.8	13.0	4.3	5.8
African-American/Black	32	81.3	9.4	3.1	6.3
Hispanic	99	91.9	6.1	1.0	1.0
Other	7	85.7	14.3	0.0	0.0
Region					
1 Panhandle	7	100.0	0.0	0.0	0.0
2 North Plains	8	100.0	0.0	0.0	0.0
3 North Central	52	75.0	13.5	5.8	5.8
4 Northeast	9	100.0	0.0	0.0	0.0
5 East	16	75.0	12.5	6.3	6.3
6 Southeast	37	89.2	2.7	2.7	5.4
7 Central	18	94.4	5.6	0.0	0.0
8 Southwest	26	73.1	26.9	0.0	0.0
9 West	6	100.0	0.0	0.0	0.0
10 Far West (Mountain)	16	93.8	6.3	0.0	0.0
11 Rio Grande Valley	12	91.7	0.0	0.0	8.3
Language of interview					
English	181	83.4	9.9	2.8	3.9
Spanish	26	96.2	3.8	0.0	0.0

Department of Family and Protective Services (DFPS)

Table 28
Satisfaction with Substitute Care under Texas DFPS:
Youth with a Physical Disability

	Percentage responding			
	Agree	Somewhat agree	Somewhat disagree	Disagree
It wasn't difficult/It was easy to get the benefits or services needed from Substitute Care under the Texas Department of Family and Protective Services (DFPS). (n=235) ³⁵	65.3	12.8	8.0	13.9
The length of time waited to receive benefits or services from Substitute Care under the Texas Department of Family and Protective Services (DFPS) was reasonable. (n=230) ³⁶	74.5	11.3	4.7	9.5
Overall, I/youth is satisfied with the benefits or services received from Substitute Care under the Texas Department of Family and Protective Services (DFPS). (n=237) ³⁷	74.0	13.9	4.6	7.6

³⁵ The wording of this question was slightly different for two age groups. The parent or guardian of youth under age 18 answered the question, "It wasn't difficult to get the benefits or services needed." Youth ages 18-21 or their parent or guardian answered the question, "It was easy to get the benefits or services needed." For Spanish-speaking youth age 18 to 21, this question read "It was difficult to get the benefits or services needed." The answers for Spanish-speaking youth age 18 to 21 were recoded from agree to disagree, somewhat agree to somewhat disagree, somewhat disagree to somewhat agree, and disagree to agree to be consistent with the language used for other respondents. A total of 235 respondents, or 96.7 percent of all respondents, answered this question. Of the remaining respondents, 2.8 percent answered "don't know" and 0.5 percent refused to answer the question.

³⁶ A total of 230 respondents, or 94.6 percent of all respondents, answered this question. Of the remaining respondents, 4.6 percent answered "don't know" and 0.8 percent refused to answer the question.

³⁷ A total of 237 respondents, or 97.6 percent of all respondents, answered this question. Of the remaining respondents, 2.0 percent answered "don't know" and 0.4 percent refused to answer the question.

Not difficult/Easy to get benefits or services

- Seventy-eight percent of DFPS SCS respondents indicated that they either agreed (65.3 percent) or somewhat agreed (12.8 percent) with the statement, “It wasn’t difficult/It was easy to get the benefits or services needed from Substitute Care under the Texas Department of Family and Protective Services (DFPS).” (see Table 28). The survey included only SCS youth with a physical disability.
- While none of the cross-tabulations about the ease of getting benefits or services were statistically significant, the responses of DFPS SCS respondents broken down by demographic groups are shown in Table 29.

**Table 29
Not Difficult/Easy to Get Benefits or Services from DFPS SCS
by Selected Demographics**

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	33	66.7	6.1	6.1	21.2
2 to 4	51	64.7	11.8	9.8	13.7
5 to 7	36	50.0	13.9	16.7	19.4
8 to 12	42	66.7	16.7	7.1	9.5
13 to 17	51	68.6	13.7	3.9	13.7
18 to 21	24	79.2	12.5	4.2	4.2
Gender of youth					
Male	125	65.6	12.0	7.2	15.2
Female	110	64.5	13.6	9.1	12.7
Ethnicity of youth					
White	89	55.1	18.0	10.1	16.9
African-American/Black	76	73.7	9.2	6.6	10.5
Hispanic	60	68.3	10.0	6.7	15.0
Other	10	70.0	10.0	10.0	10.0
Region					
1 Panhandle	17	76.5	11.8	5.9	5.9
2 North Plains	12	66.7	0.0	16.7	16.7
3 North Central	58	62.1	13.8	8.6	15.5
4 Northeast	12	83.3	8.3	0.0	8.3
5 East	9	44.4	11.1	22.2	22.2
6 Southeast	40	70.0	10.0	2.5	17.5
7 Central	39	53.8	17.9	10.3	17.9
8 Southwest	21	66.7	14.3	14.3	4.8
9 West	5	80.0	20.0	0.0	0.0
10 Far West (Mountain)	4	50.0	0.0	0.0	50.0
11 Rio Grande Valley	15	73.3	20.0	6.7	0.0

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Language of interview					
English	231	65.4	12.6	8.2	13.9
Spanish	4	50.0	25.0	0.0	25.0

Length of time waited to receive benefits or services was reasonable

- Eighty-six percent of DFPS SCS respondents reported they either agreed (74.5 percent) or somewhat agreed (11.3 percent) that the length of time they waited to receive benefits or services from the agency was reasonable.
- While none of the cross-tabulations about the reasonableness of time waited to receive benefits or services from DFPS SCS were statistically significant, the responses of DFPS SCS respondents broken down by demographic groups are shown in Table 30.

Table 30
Length of Time Waited to Receive DFPS SCS Benefits or Services Was Reasonable by Selected Demographics

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	32	78.1	3.1	9.4	9.4
2 to 4	48	77.1	12.5	4.2	6.3
5 to 7	36	50.0	16.7	11.1	22.2
8 to 12	39	79.5	15.4	0.0	5.1
13 to 17	52	76.9	9.6	3.8	9.6
18 to 21	23	87.0	8.7	0.0	4.3
Gender of youth					
Male	123	72.4	11.4	4.9	11.4
Female	107	76.6	11.2	4.7	7.5
Ethnicity of youth					
White	86	62.8	17.4	5.8	14.0
African-American/Black	73	83.6	8.2	4.1	4.1
Hispanic	62	79.0	6.5	4.8	9.7
Other	10	80.0	10.0	0.0	10.0

PART 1 – HHS ENTERPRISE CUSTOMER SATISFACTION SURVEY

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Agree
Region					
1 Panhandle	16	81.2	6.3	6.3	6.3
2 North Plains	10	80.0	0.0	10.0	10.0
3 North Central	58	70.7	12.1	5.2	12.1
4 Northeast	12	91.7	8.3	0.0	0.0
5 East	9	66.7	11.1	0.0	22.2
6 Southeast	39	69.2	10.3	7.7	12.8
7 Central	37	73.0	13.5	2.7	10.8
8 Southwest	21	76.2	14.3	9.5	0.0
9 West	5	80.0	20.0	0.0	0.0
10 Far West (Mountain)	4	100.0	0.0	0.0	0.0
11 Rio Grande Valley	16	75.0	18.8	0.0	6.3
Language of interview					
English	226	74.3	11.1	4.9	9.7
Spanish	4	75.0	25.0	0.0	0.0

Overall satisfaction with benefits or services received

- Eighty-eight percent of DFPS SCS respondents indicated they either agreed (74.0 percent) or somewhat agreed (13.9 percent) that they were satisfied overall with the benefits or services they received from the agency.
- None of the cross-tabulations about overall satisfaction with benefits or services received from DFPS SCS were statistically significant. The responses of DFPS SCS respondents broken down by demographic groups are shown in Table 31.

**Table 31
Overall Satisfaction with Benefits or Services Received from DFPS SCS
by Selected Demographics**

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	34	76.5	8.8	8.8	5.9
2 to 4	49	75.5	16.3	4.1	4.1
5 to 7	36	61.1	16.7	11.1	11.1
8 to 12	41	73.2	17.1	2.4	7.3
13 to 17	52	75.0	13.5	0.0	11.5
18 to 21	25	84.0	8.0	4.0	4.0
Gender of youth					
Male	127	74.0	15.0	3.9	7.1
Female	110	73.6	12.7	5.5	8.2

PART 1 – HHS ENTERPRISE CUSTOMER SATISFACTION SURVEY

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Ethnicity of youth					
White	91	71.4	14.3	6.6	7.7
African-American/Black	4	74.3	16.2	4.1	5.4
Hispanic	5	79.4	11.1	1.6	7.9
Other	2	60.0	10.0	10.0	20.0
Region					
1 Panhandle	17	88.2	11.8	0.0	0.0
2 North Plains	12	66.7	25.0	0.0	8.3
3 North Central	60	65.0	20.0	5.0	10.0
4 Northeast	12	75.0	16.7	8.3	0.0
5 East	9	88.9	0.0	0.0	11.1
6 Southeast	39	74.4	7.7	5.1	12.8
7 Central	39	76.9	10.3	5.1	7.7
8 Southwest	21	76.2	9.5	9.5	4.8
9 West	5	80.0	20.0	0.0	0.0
10 Far West (Mountain)	4	100.0	0.0	0.0	0.0
11 Rio Grande Valley	16	75.0	25.0	0.0	0.0
Language of interview					
English	233	73.8	13.7	4.7	7.7
Spanish	4	75.0	25.0	0.0	0.0

Department of State Health Services (DSHS)

**Table 32
Satisfaction with Children with Special Health Care Needs Services Program
under Texas DSHS**

	Percentage responding			
	Agree	Somewhat agree	Somewhat disagree	Disagree
It wasn't difficult/It was easy to get the benefits or services needed from the Special Health Care Needs Services Program under the Texas Department of State Health Services (DSHS). (n=170) ³⁸	71.2	16.6	4.1	8.0
The length of time waited to receive benefits or services from the Special Health Care Needs Services Program under the Texas Department of State Health Services (DSHS) was reasonable. (n=170) ³⁹	74.5	13.1	7.3	5.1
Overall, I/youth is satisfied with the benefits or services received from the Special Health Care Needs Services Program under the Texas Department of State Health Services (DSHS). (n=170) ⁴⁰	84.4	7.5	3.6	4.5

³⁸ The wording of this question was slightly different for two age groups. The parent or guardian of youth under age 18 answered the question, "It wasn't difficult to get the benefits or services needed." Youth ages 18-21 or their parent or guardian answered the question, "It was easy to get the benefits or services needed." For Spanish-speaking youth age 18 to 21, this question read "It was difficult to get the benefits or services needed." The answers for Spanish-speaking youth age 18 to 21 were recoded from agree to disagree, somewhat agree to somewhat disagree, somewhat disagree to somewhat agree, and disagree to agree to be consistent with the language used for other respondents. A total of 170 respondents, or 98.6 percent of all respondents, answered this question. Of the remaining respondents, 1.4 percent answered "don't know" and 0.0 percent refused to answer the question.

³⁹ A total of 170 respondents, or 98.6 percent of all respondents, answered this question. Of the remaining respondents, 1.4 percent answered "don't know" and 0.0 percent refused to answer the question.

⁴⁰ A total of 170 respondents, or 98.6 percent of all respondents, answered this question. Of the remaining respondents, 1.4 percent answered "don't know" and 0.0 percent refused to answer the question.

Not difficult/Easy to get benefits or services

- As shown in Table 32, 87.8 percent of DSHS CSHCN Program respondents indicated that they either agreed (71.2 percent) or somewhat agreed (16.6 percent) with the statement, “It wasn’t difficult/It was easy to get the benefits or services needed from the Special Health Care Needs Services Program under the Texas Department of State Health Services (DSHS).”
- While none of the cross-tabulations about the ease of getting benefits or services were statistically significant, the responses of DSHS CSHCN Program respondents broken down by demographic groups are shown in Table 33.

**Table 33
Not Difficult/Easy to Get Benefits or Services from DSHS CSHCN Program
by Selected Demographics**

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	1	100.0	0.0	0.0	0.0
2 to 4	8	62.5	12.5	12.5	12.5
5 to 7	15	86.7	6.7	0.0	6.7
8 to 12	50	74.0	10.0	10.0	6.0
13 to 17	49	71.4	20.4	2.0	6.1
18 to 21	45	66.7	24.4	0.0	8.9
Gender of youth					
Male	85	76.5	14.1	1.2	8.2
Female	84	66.7	19.0	7.1	7.1
Ethnicity of youth					
White	25	52.0	32.0	8.0	8.0
African-American/Black	4	50.0	0.0	0.0	50.0
Hispanic	118	76.3	12.7	4.2	6.8
Other	6	100.0	0.0	0.0	0.0
Region					
1 Panhandle	8	87.5	0.0	0.0	12.5
2 North Plains	4	75.0	0.0	25.0	0.0
3 North Central	54	64.8	27.8	1.9	5.6
4 Northeast	9	88.9	11.1	0.0	0.0
5 East	1	100.0	0.0	0.0	0.0
6 Southeast	30	76.7	6.7	3.3	13.3
7 Central	6	50.0	16.7	0.0	33.3
8 Southwest	15	53.3	26.7	13.3	6.7
9 West	2	50.0	50.0	0.0	0.0
10 Far West (Mountain)	13	76.9	15.4	7.7	0.0
11 Rio Grande Valley	27	77.8	11.1	0.0	11.1

		Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Language of interview					
English	90	63.3	21.1	6.7	8.9
Spanish	80	80.0	11.3	1.3	7.5

Length of time waited to receive benefits or services was reasonable

- Eighty-eight percent of DSHS CSHCN Program respondents reported they either agreed (74.5 percent) or somewhat agreed (13.1 percent) that the length of time they waited to receive benefits or services from the agency was reasonable.
- As shown in Table 34, Spanish-speaking respondents were more likely than English-speaking respondents to agree that the length of time youth waited to receive benefits or services from DSHS CSHCN Program was reasonable. The other cross-tabulations were not statistically significant.

Table 34
Length of Time Waited to Receive DSHS CSHCN Program Benefits or Services Was Reasonable by Selected Demographics

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	1	100.0	0.0	0.0	0.0
2 to 4	8	62.5	12.5	25.0	0.0
5 to 7	14	57.1	21.4	14.3	7.1
8 to 12	51	78.4	3.9	11.8	5.9
13 to 17	50	80.0	16.0	2.0	2.0
18 to 21	45	75.6	15.6	2.2	6.7
Gender of youth					
Male	87	75.9	12.6	3.4	8.0
Female	83	72.3	14.5	10.8	2.4
Ethnicity of youth					
White	25	64.0	8.0	12.0	16.0
African-American/Black	4	75.0	0.0	0.0	25.0
Hispanic	118	78.8	12.7	6.8	1.7
Other	5	80.0	20.0	0.0	0.0

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Region					
1 Panhandle	8	62.5	25.0	0.0	12.5
2 North Plains	4	75.0	0.0	25.0	0.0
3 North Central	54	70.4	16.7	7.4	5.6
4 Northeast	8	100.0	0.0	0.0	0.0
5 East	3	66.7	33.3	0.0	0.0
6 Southeast	28	82.1	3.6	7.1	7.1
7 Central	6	66.7	16.7	0.0	16.7
8 Southwest	15	60.0	20.0	20.0	0.0
9 West	2	100.0	0.0	0.0	0.0
10 Far West (Mountain)	13	84.6	15.4	0.0	0.0
11 Rio Grande Valley	26	80.8	11.5	3.8	3.8
Language of interview**					
English	90	64.4	14.4	11.1	10.0
Spanish	80	86.3	11.3	2.5	0.0

Overall satisfaction with benefits or services received

- Ninety-two percent of DSHS CSHCN Program respondents indicated they either agreed (84.4 percent) or somewhat agreed (7.5 percent) that they were satisfied overall with the benefits or services they received from DSHS CSHCN Program.
- None of the cross-tabulations about overall satisfaction with benefits or services received from DSHS CSHCN Program were statistically significant. The responses of DSHS CSHCN Program respondents broken down by demographic groups are shown in Table 35.

Table 35

Overall Satisfaction with Benefits or Services Received from DSHS CSHCN Program by Selected Demographics

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	1	100.0	0.0	0.0	0.0
2 to 4	8	62.5	12.5	12.5	12.5
5 to 7	14	92.9	7.1	0.0	0.0
8 to 12	50	84.0	6.0	4.0	6.0
13 to 17	49	91.8	2.0	2.0	4.1
18 to 21	45	82.2	13.3	2.2	2.2

PART 1 – HHS ENTERPRISE CUSTOMER SATISFACTION SURVEY

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Gender of youth					
Male	86	84.9	5.8	5.8	3.5
Female	83	84.3	9.6	1.2	4.8
Ethnicity of youth					
White	26	80.8	15.4	0.0	3.8
African-American/Black	4	75.0	0.0	0.0	25.0
Hispanic	118	86.4	5.9	4.2	3.4
Other	6	100.0	0.0	0.0	0.0
Region					
1 Panhandle	8	87.5	0.0	0.0	12.5
2 North Plains	4	75.0	25.0	0.0	0.0
3 North Central	54	85.2	11.1	1.9	1.9
4 Northeast	8	100.0	0.0	0.0	0.0
5 East	3	100.0	0.0	0.0	0.0
6 Southeast	30	83.3	6.7	6.7	3.3
7 Central	5	100.0	0.0	0.0	0.0
8 Southwest	15	53.3	26.7	6.7	13.3
9 West	2	100.0	0.0	0.0	0.0
10 Far West (Mountain)	13	84.6	0.0	7.7	7.7
11 Rio Grande Valley	26	92.3	0.0	3.8	3.8
Language of interview					
English	89	77.5	11.2	5.6	5.6
Spanish	79	93.7	2.5	1.3	2.5

Health and Human Services Commission (HHSC)

**Table 36
Satisfaction with Personal Care Services under Texas HHSC**

	Percentage responding			
	Agree	Somewhat agree	Somewhat disagree	Disagree
It wasn't difficult/It was easy for me to get the benefits or services needed from the Personal Care Services under the Texas Health and Human Services Commission (HHSC). (n=183) ⁴¹	63.5	17.7	7.2	11.6
The length of time waited to receive benefits or services from the Personal Care Services under the Texas Health and Human Services Commission (HHSC) was reasonable. (n=185) ⁴²	67.3	17.6	4.3	10.7
Overall, I/youth is satisfied with the benefits or services received from the Personal Care Services under the Texas Health and Human Services Commission (HHSC). (n=184) ⁴³	84.7	10.9	1.2	3.2

⁴¹ The wording of this question was slightly different for two age groups. The parent or guardian of youth under age 18 answered the question, "It wasn't difficult to get the benefits or services needed." Youth ages 18-21 or their parent or guardian answered the question, "It was easy to get the benefits or services needed." For Spanish-speaking youth age 18 to 21, this question read "It was difficult to get the benefits or services needed." The answers for Spanish-speaking youth age 18 to 21 were recoded from agree to disagree, somewhat agree to somewhat disagree, somewhat disagree to somewhat agree, and disagree to agree to be consistent with the language used for other respondents. A total of 183 respondents, or 97.1 percent of all respondents, answered this question. Of the remaining respondents, 2.9 percent answered "don't know" and 0.0 percent refused to answer the question.

⁴² A total of 185 respondents, or 98.4 percent of all respondents, answered this question. Of the remaining respondents, 1.6 percent answered "don't know" and 0.0 percent refused to answer the question.

⁴³ A total of 184 respondents, or 97.9 percent of all respondents, answered this question. Of the remaining respondents, 1.6 percent answered "don't know" and 0.6 percent refused to answer the question.

Not difficult/Easy to get benefits or services

- Eighty-one percent of HHSC PCS respondents indicated that they either agreed (63.5 percent) or somewhat agreed (17.7 percent) with the statement, “It wasn’t difficult/It was easy to get the benefits or services needed from the Personal Care Services under the Texas Health and Human Services Commission (HHSC).” (see Table 36).
- While none of the cross-tabulations about the ease of getting benefits or services were statistically significant, the responses of HHSC PCS respondents broken down by demographic groups are shown in Table 37.

**Table 37
Not Difficult/Easy to Get Benefits or Services from HHSC PCS
by Selected Demographics**

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	3	33.3	66.7	0.0	0.0
2 to 4	8	87.5	0.0	0.0	12.5
5 to 7	30	63.3	20.0	3.3	13.3
8 to 12	54	59.3	24.1	5.6	11.1
13 to 17	45	66.0	10.6	12.8	10.6
18 to 21	37	67.6	16.2	5.4	10.8
Gender of youth					
Male	103	62.1	16.5	7.8	13.6
Female	80	65.0	20.0	6.3	8.8
Ethnicity of youth					
White	33	51.5	27.3	9.1	12.1
African-American/Black	24	66.7	8.3	4.2	20.8
Hispanic	92	67.4	17.4	5.4	9.8
Other	7	57.1	0.0	28.6	14.3
Region					
1 Panhandle	9	66.7	22.2	11.1	0.0
2 North Plains	4	25.0	75.0	0.0	0.0
3 North Central	21	66.7	4.8	4.8	23.8
4 Northeast	11	36.4	36.4	9.1	18.2
5 East	10	80.0	10.0	10.0	0.0
6 Southeast	28	64.3	14.3	7.1	14.3
7 Central	12	50.0	25.0	8.3	16.7
8 Southwest	22	54.5	22.7	4.5	18.2
9 West	2	50.0	0.0	50.0	0.0
10 Far West (Mountain)	4	50.0	50.0	0.0	0.0
11 Rio Grande Valley	58	74.1	12.1	6.9	6.9

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Language of interview					
English	157	63.7	16.6	7.0	12.7
Spanish	25	64.0	24.0	8.0	4.0

Length of time waited to receive benefits or services was reasonable

- Eighty-five percent of HHSC PCS respondents reported they either agreed (67.3 percent) or somewhat agreed (17.6 percent) that the length of time they waited to receive benefits or services from the agency was reasonable.
- While none of the cross-tabulations about the reasonableness of time waited to receive benefits or services from HHSC PCS were statistically significant, the responses of HHSC PCS respondents broken down by demographic groups are shown in Table 38.

Table 38
Length of Time Waited to Receive HHSC PCS Benefits or Services Was Reasonable by Selected Demographics

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	3	33.3	33.3	0.0	33.3
2 to 4	8	87.5	0.0	0.0	12.5
5 to 7	31	54.8	29.0	6.5	9.7
8 to 12	54	68.5	20.4	3.7	7.4
13 to 17	47	70.2	14.9	4.3	10.6
18 to 21	40	70.0	12.5	5.0	12.5
Gender of youth					
Male	105	68.6	14.3	4.8	12.4
Female	81	65.4	22.2	3.7	8.6
Ethnicity of youth					
White	33	66.7	15.2	12.1	6.1
African-American/Black	24	66.7	16.7	4.2	12.5
Hispanic	93	69.9	17.2	3.2	9.7
Other	6	66.7	0.0	0.0	33.3

PART 1 – HHS ENTERPRISE CUSTOMER SATISFACTION SURVEY

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Region					
1 Panhandle	10	70.0	20.0	10.0	0.0
2 North Plains	4	50.0	50.0	0.0	0.0
3 North Central	21	66.7	9.5	9.5	14.3
4 Northeast	11	45.5	18.2	9.1	27.3
5 East	10	80.0	10.0	0.0	10.0
6 Southeast	28	67.9	17.9	3.6	10.7
7 Central	12	50.0	25.0	8.3	16.7
8 Southwest	22	59.1	27.3	4.5	9.1
9 West	3	100.0	0.0	0.0	0.0
10 Far West (Mountain)	4	75.0	25.0	0.0	0.0
11 Rio Grande Valley	58	74.1	13.8	1.7	10.3
Language of interview					
English	159	66.0	17.6	5.0	11.3
Spanish	26	76.9	15.4	0.0	7.7

Overall satisfaction with benefits or services received

- Ninety-six percent of HHSC PCS respondents indicated they either agreed (84.7 percent) or somewhat agreed (10.9 percent) that they were satisfied overall with the benefits or services they received from the agency.
- None of the cross-tabulations about overall satisfaction with benefits or services received from HHSC PCS were statistically significant. The responses of HHSC PCS respondents broken down by demographic groups are shown in Table 39.

**Table 39
Overall Satisfaction with Benefits or Services Received from HHSC PCS
by Selected Demographics**

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Age of youth					
Under age 2	3	100.0	0.0	0.0	0.0
2 to 4	9	100.0	0.0	0.0	0.0
5 to 7	29	75.9	17.2	0.0	6.9
8 to 12	55	81.8	16.4	1.8	0.0
13 to 17	48	89.6	4.2	2.1	4.2
18 to 21	40	85.0	10.0	0.0	5.0
Gender of youth					
Male	103	89.3	8.7	0.0	1.9
Female	81	79.0	13.6	2.5	4.9

PART 1 – HHS ENTERPRISE CUSTOMER SATISFACTION SURVEY

	Count	Percentage responding			
		Agree	Somewhat agree	Somewhat disagree	Disagree
Ethnicity of youth					
White	31	80.6	16.1	3.2	0.0
African-American/Black	24	75.0	16.7	0.0	8.3
Hispanic	93	88.2	8.6	1.1	2.2
Other	6	66.7	16.7	0.0	16.7
Region					
1 Panhandle	10	80.0	20.0	0.0	0.0
2 North Plains	4	75.0	25.0	0.0	0.0
3 North Central	21	76.2	23.8	0.0	0.0
4 Northeast	10	70.0	20.0	0.0	10.0
5 East	10	80.0	0.0	10.0	10.0
6 Southeast	28	92.9	0.0	0.0	7.1
7 Central	12	83.3	16.7	0.0	0.0
8 Southwest	21	76.2	19.0	4.8	0.0
9 West	3	100.0	0.0	0.0	0.0
10 Far West (Mountain)	4	100.0	0.0	0.0	0.0
11 Rio Grande Valley	60	90.0	6.7	0.0	3.3
Language of interview					
English	157	83.4	12.1	1.3	3.2
Spanish	27	92.6	3.7	0.0	3.7

V. CONCLUSION

In March, April and May 2010, the University of North Texas Survey Research Center conducted a survey of youths age 18 to 21 and parents/guardians of youths under the age of 18 enrolled in HHS services to assess their satisfaction with the benefits and/or services provided by one of five HHS agencies.

These customer satisfaction findings indicate that very large proportions of the CSHCN customers in the included programs were satisfied with the benefits or services they received once they obtained program benefits or services. Also, for most of the agencies, large proportions of the customers thought the length of time they waited for services was reasonable and that it was not difficult (or was easy) to get services.

For most of the included programs, customers were more likely to report being satisfied with the services they received than they were to report that the length of time they waited for services was reasonable. Similarly, customers in each of the included programs were more likely to report being satisfied with the services they received than they were to report that it was not difficult (or it was easy) to get services.

VI. HHS RESPONSE

For most of the included programs, customers were more likely to report being satisfied with the services they received than they were to report that the length of time they waited for services was reasonable. This is not a surprising finding. Many HHS programs have funding constraints that limit the availability of services. This result cannot be interpreted accurately without considering the supply versus the demand for each program's services. HHS agencies will look for ways to decrease program wait times and improve customer service to help those waiting for services understand the situation

Customers in each of the included programs were also more likely to report being satisfied with the services they received than they were to report that it was not difficult (or it was easy) to get services. This result is likely to be influenced by wait times, and an accurate interpretation would have to consider the supply versus demand for each program's services as described above. However, HHS programs will re-examine the application process to determine if there are any ways to make it easier for customers. HHS programs re-examine the application process regularly, and the renewed emphasis on customer service will involve taking a fresh look for ways to streamline the process.

PART 2 - AGENCY CUSTOMER SURVEYS

HHS agencies independently conduct surveys that include questions about customer satisfaction with specific agency programs and services. Some surveys focus entirely on customer satisfaction, and others include customer satisfaction as one of several service categories being assessed. Part two of this report presents the descriptions and major findings of the following surveys that cover customer satisfaction.

Texas Department of Aging and Disability Services (DADS)

- **2009 Long-Term Services and Supports Quality Review (LTSSQR).** In-person interviews were conducted from December 2008 to March 2009 with individuals or their representatives who were identified as receiving long-term services and supports in December 2008. The LTSSQR surveys customers about their perception of the quality of long-term services and supports administered by the DADS and trends in long-term services and supports over time.
- **Nursing Facility Quality Review (NFQR) in Texas 2009 survey report.** In-person interviews were conducted from March 2009 through May 2009 with individuals living in Medicaid-certified nursing facilities in Texas during those months. The NFQR is a statewide process used by DADS to benchmark and trend the quality of care and the quality of life for individuals in nursing facilities across the state.

Department of Assistive and Rehabilitative Services (DARS)

- **Division for Blind Services (DBS) Customer Service Survey.** A telephone-based consumer satisfaction survey was conducted on a quarterly basis during state fiscal year (SFY) 2009 with individuals completing the program of services in the Vocational Rehabilitation, Independent Living, or Blind Children’s Vocational Discovery and Development programs. This survey assesses the level of consumer satisfaction in terms of interaction with DBS staff, and the quality and effectiveness of the services they receive.
- **Division Rehabilitation Services (DRS) Vocational Rehabilitation Consumer Satisfaction Survey.** This summary presents the SFY2008 and SFY2009 results from an ongoing customer satisfaction survey with vocational rehabilitation consumers whose cases were closed. The intent of this report is to provide DRS management and staff with ongoing feedback from Vocational Rehabilitation consumers in order to identify strengths and weaknesses, to develop strategies on providing excellent services to consumers, and to determine areas of needed improvement.
- **DRS Independent Living Services Consumer Satisfaction Survey.** This summary presents the SFY2008 results of an ongoing customer satisfaction survey of independent living consumers whose cases were closed. The intent of this report is to provide DRS management and staff with ongoing feedback from Independent Living Services consumers in order to identify strengths and weaknesses, to develop strategies on

providing excellent services to consumers, and to determine areas of needed improvement.

- **Early Childhood Intervention Family Survey Results SFY2009.** The Family Outcomes Survey, a mail-based family survey, was conducted from February through March 2009 with the parents of children enrolled in the DARS Early Childhood Intervention program in Texas during SFY2009. This survey assesses how helpful services are for families and their child enrolled in the ECI program, families' reported ability to access other services and supports; and their reported competencies in helping their child develop and learn.

Department of Family and Protective Services (DFPS)

- **Adult Protective Services Community Satisfaction Survey.** The online and mail-based 2009 Texas Adult Protective Services Community Satisfaction Survey was conducted in May 2009 with members of the judiciary, law enforcement agencies, community organizations and resource groups, and Adult Protective Services Community Boards. The purpose is to solicit information regarding DFPS performance in providing investigative and adult protective services.
- **Improving the Quality of Services to Youth in Substitute Care: A Report on Surveyed Youth in Foster Care SFY2007, Texas Department of Family and Protective Services, September 2008.** This summary presents the 2007 results of two surveys of youth in foster care.
 - The Annual Random Youth Survey, mandated by Texas Legislature, is an annual telephone-based survey conducted between July and October 2007 with youth ages 14 to 17 receiving foster care services on or during April 30, 2007.⁴⁴ The survey measures respondents' views of the services provided to them in preparation for adult living, including the quality of the substitute care services provided to them, any improvements to support youth in care, and additional factors DFPS considers relevant to program enhancement.
 - The Youth Questionnaire, created by alumni of the Texas foster care system and Child Protective Services (CPS) staff, is part of an ongoing effort to obtain feedback from youth being discharged from foster care. The questionnaire obtains feedback about the quality of the youth's most recent foster care placement and how the placement helped prepare them for adult living.

Department of State Health Services (DSHS)

- **The Children with Special Health Care Needs (CSHCN) Services Program 2009 Parent Survey Report.** Focus groups and written parent surveys were conducted from June 2008 through March 2009 with parents of children affiliated with the CSHCN Services Program at the time of the survey. The focus groups and survey were

⁴⁴ Senate Bill 6, 79th Texas Legislature, 2005.

assessments of the needs of parents and family members and the health care and related services they received, focusing on the Title V national and state performance measures.

- **The Children with Special Health Care Needs (CSHCN) Services Program 2009 Provider Survey Report.** An online survey was conducted from March 2009 through May 2009 with health care providers for children with special health care needs. The survey gathered information on the extent that providers understood and demonstrated accord with the Texas Title V national and state performance measures for children and youth with special health care needs.
- **The Children with Special Health Care Needs (CSHCN) Services Program 2009 Community Resource Coordination Groups Survey Report.** An online survey was conducted from March 2009 through April 2009 with participants in Community Resource Coordination Groups (CRCG) across Texas. The survey gathered information on the extent that CRCG participants understood and demonstrated accord with the Texas Title V national and state performance measures for children and youth with special health care needs

Health and Human Services Commission (HHSC)

- **The Children’s Health Insurance Program (CHIP) in Texas: The Disenrollee Survey SFY2008.** This telephone-based survey was conducted from February 2008 through June 2008 with families of children recently disenrolled from CHIP in Texas. The purpose of this survey is to provide a demographic profile of children recently disenrolled from CHIP and their families, and determine their reasons for disenrollment.
- **The Children’s Health Insurance Program (CHIP) in Texas: The Established Enrollee Survey Report SFY2008.** This telephone-based survey was conducted from February 2008 through August 2008 with families of children enrolled in CHIP in Texas for at least 9 months prior to the study period. The survey results provide a demographic and health profile of children enrolled in CHIP, an assessment of parents’ experiences and satisfaction with their children’s healthcare, and a comparison of findings across the 17 health plans participating in CHIP during SFY2007.
- **The Children’s Health Insurance Program (CHIP) in Texas: The New Enrollee Survey SFY2008.** This telephone-based survey was conducted from February 2008 through May 2008 with families of children newly enrolled in CHIP in Texas. The survey results provide a demographic profile of new CHIP members and their families, information on the experiences of families during the application and enrollment process, and an assessment of the healthcare utilization and access to care for new CHIP enrollees.
- **Texas STAR+PLUS Enrollee Survey Report SFY2009.** This telephone-based survey was conducted from December 2008 through April 2009 with individuals enrolled in the Texas Medicaid STAR+PLUS Program for at least 9 consecutive months between September 2007 and August 2008. The survey results provide a demographic and health profile of STAR+PLUS members, documentation of healthy behaviors and health promotion activities, and an assessment of enrollees’ experiences and satisfaction with getting urgent, routine, and specialty care and care coordination services.

I. TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)

2009 Long-Term Services and Supports Quality Review

Purpose

The purpose of this report is to present the results of the 2009 Long-Term Services and Supports Quality Review (LTSSQR), which consisted of in-person interviews conducted from December 2008 to March 2009 with individuals or their representatives who were identified as receiving long-term services and supports in December 2008. The LTSSQR surveys customers about their perception of the quality of long-term services and supports administered by the Texas Department of Aging and Disability Services (DADS) and trends in long-term services and supports over time. Individuals can receive one of two LTSSQR surveys: the National Core Indicators (NCI) survey or the Participant Experience Survey (PES). Specifically, the intent of this report is to describe:

- general observations from the 2009 LTSSQR, and
- statistically significant findings within a program , across programs, or across years.⁴⁵

The current summary presents data for the following programs:

- Community-Based Alternatives (CBA) - Consumer Directed Services (CDS) and non-CDS option
- Community Living Assistance and Support Services (CLASS) - CDS and non-CDS
- Consolidated Waiver Program (CWP)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-Based Services (HCS)
- Large Intermediate Care Facilities for People with Mental Retardation (ICF/MR)
- Small or Medium ICF/MR
- State Supported Living Centers (SSLC)

⁴⁵ Responses were totaled by question then frequencies and percents were calculated by program and year. Data were said to be statistically significant if the probability of a difference between two values being compared was due to chance 1 time out of 100 times ($p \leq .01$).

- Texas Home Living Waiver (TxHmL)

Sample

An individual identified as receiving long-term services and supports in December 2008 who was enrolled in one of the programs listed above was eligible for inclusion in the sample.

A random sample stratified by county was pulled to achieve a sample size with a 95 percent confidence level and 5 percent confidence interval for each program.

DADS contacted 5,754 individuals for participation in the survey. Three-hundred and three people refused participation. LTSSQR 2009 reports on data collected from 5,332 adults for a participation rate of 93 percent. Of the 5,332 surveys completed, 5,178 were validated and used for analyses.

Summary of Major Findings

General observations for 2009 include:

- Long-term services and supports facilitate personal goals, health, and well-being.⁴⁶
 - Ninety-four percent to 99 percent of people reported that their services and supports addressed their health and well-being.
 - Ninety-two percent to 98 percent of people reported that their services and supports helped them achieve their personal goals.
- Most people received the services they needed and were satisfied with information about how to access services and support.⁴⁷
 - Eighty-one percent to 98 percent of people reported that they received the services they needed.
 - Ninety percent to 96 percent of people reported being satisfied with information received about how to apply for services.
 - Eighty-seven percent to 97 percent of people reported being satisfied with information received about available services.
- At least three out of four people reported feeling happy with their personal life.⁴⁸

⁴⁶ Finding applies to 2009 data for CBA (non-CDS), CLASS (non-CDS), CWP, DBMD, HCS, TxHmL, small or medium ICFs/MR, large ICFs/MR, and SSLCs.

⁴⁷ Finding applies to 2009 data for CLASS (non-CDS), CWP, DBMD, HCS, TxHmL, small or medium ICFs/MR, large ICFs/MR, SSLCs.

⁴⁸ Finding applies to 2009 data for CLASS (non-CDS), CWP, DBMD, HCS, TxHmL, small or medium ICFs/MR, large ICFs/MR, and SSCLs.

- Feeling lonely often⁴⁹ was consistent with findings from a 2007 study on people from five states who reported feeling lonely often (Stancliffe et al., 2007).⁵⁰ The study's authors suggested that increasing social contact and compatibility with roommates, decreasing fear with where one lives,⁵¹ and increasing choice with where and with whom one lives with⁵² may help address loneliness.

The following improvements ($p \leq .01$) in services and supports were observed across programs over time:

- Access to transportation;⁵³
- Autonomy to use the phone whenever the person wanted;⁵⁴ and
- Choice to decide how to spend free time;⁵⁵

The following opportunities for improvement were observed across programs:

- Access to timely preventive care;⁵⁶
- Autonomy to take risks;⁵⁷
- Choice of staff⁵⁸ or case manager⁵⁹;
- Control over transportation⁶⁰ and spending money⁶¹; and
- Privacy when visiting with guests;⁶²

The following trends were observed ($p \leq .01$):

⁴⁹ Finding applies to 2009 data for CLASS (non-CDS), CWP, DBMD, HCS, TxHmL, small or medium ICFs/MR, large ICFs/MR, and SSLCs.

⁵⁰ Stancliffe et al. (2007). Loneliness and living arrangements. *Intellectual and Developmental Disabilities*, 45(6), 380-390.

⁵¹ Ibid.

⁵² Stancliffe, R. J., Lakin, C., Taub, S., Chiri, G., & Byun, S. (2009). Satisfaction and sense of well being among Medicaid ICF/MR and HCBS recipients in six states. *Intellectual and Developmental Disabilities*, 47(2), 63-83.

⁵³ Finding applies to CBA (non-CDS) and HCS trend data.

⁵⁴ Finding applies to CWP, HCS, SSLCs, and TxHmL trend data.

⁵⁵ Finding applies to DBMD, small or medium ICFs/MR, SSLCs, and TxHmL trend data.

⁵⁶ Finding applies to HCS, large ICFs/MR, small or medium ICFs/MR, and SSLCs trend data.

⁵⁷ Finding applies to large ICFs/MR and TxHmL trend data.

⁵⁸ Finding applies to CLASS (non-CDS), HCS, and CLASS (CDS) trend data.

⁵⁹ Finding refers to CLASS (non-CDS), small or medium ICFs/MR, TxHmL, and CLASS (CDS) trend data.

⁶⁰ Finding applies to CLASS (non-CDS), HCS, small or medium ICFs/MR, TxHmL, and CLASS (CDS) trend data.

⁶¹ Finding applies to CLASS (non-CDS), HCS, small or medium ICFs/MR, SSLCs, and CLASS (CDS) trend data.

⁶² Finding applies to CLASS (non-CDS), HCS, and TxHmL trend data.

- A notable upward trend across programs was that the percentage of people who participated in self-advocacy activities has increased over time, i.e. from 2005 to 2009.⁶³
- An increase in the percentage of people who reported having a physical disability also increased over time.⁶⁴
- Two programs that offer the CDS option were included in LTSSQR 2009: CBA and CLASS. The data suggests that compared to people who did not use CDS, the people who used CDS in either CBA or CLASS had a higher degree of awareness about choosing the staff that helps them and chose their own staff.⁶⁵

Nursing Facility Quality Review (NFQR) in Texas 2009 survey report

Purpose

The purpose of this report is to present the results of the Nursing Facility Quality Review (NFQR) in-person interviews conducted from March 2009 through May 2009 with individuals living in Medicaid-certified nursing facilities in Texas during those months. The NFQR is a statewide process used by DADS to benchmark and trend the quality of care and the quality of life for individuals in nursing facilities across the state. NFQR data collected over time helps DADS to:

- track progress in quality improvement activities, and
- formulate strategies to improve both the quality of long-term services and supports and clinical outcomes of individuals.

Sample

The sample size was developed using facility census data of individuals living in a nursing facility who had a Minimum Data Set (MDS 2.0) assessment sometime from September 2008 through December 2008. The census was used to determine facility size. The sample size for each facility was based on the proportion of individuals per facility over the fourth quarter of calendar year 2008 and each individual had an equal chance of being selected into the sample.

To be eligible for inclusion in the sample, an individual (including those with Medicare, Medicaid or any other payer source) had to be living in one of the 1,048 Medicaid-certified nursing facilities in Texas when the survey was conducted (from March 2009 through May 2009).

A list of random numbers was used to determine which individual(s) would be selected into the sample. When the NACES interviewer arrived at the facility, the interviewer was instructed to

⁶³ Finding applies to HCS, large ICF/MR, small or medium ICF/MR, and SSLC trend data.

⁶⁴ Finding applies to large ICF/MR and SSLC trend data.

⁶⁵ Finding applies to 2009 data and trend data for CBA and CLASS.

obtain an alphabetized roster of individuals.⁶⁶ If the roster was not numbered, the interviewer was instructed to sequentially number the alphabetized roster. The pre-determined randomly selected number was used to identify which individual(s) on the list would be interviewed (i.e., if the random number was 23 then the 23rd person on the roster was selected). If the randomly selected individual refused to participate, was not present at the facility, or was deceased, the interviewer used another pre-determined random number to select an individual for the sample.

Among those sampled to participate in the survey, three people refused to be interviewed, 50 people were not present at the facility at the time of the survey, and three people had no specified reason for not being interviewed.⁶⁷ In these cases, another person was chosen for the survey from a roster process that allows for the replacement of a person. In total, 2,164 individuals were randomly selected, assessed, and interviewed.

The same sampling methodology was used in 2008. However, in years prior to 2008 only individuals from nursing facilities who had Minimum Data Set (MDS 2.0) assessments were included in the sample. The MDS is part of the federally mandated process for clinical assessment of all individuals in Medicare or Medicaid certified nursing homes. The MDS provides a comprehensive assessment of each individual's functional capabilities and health problems. The MDS assessment information assists nursing home staff to develop specific plans of care to address the needs of each individual (Centers for Medicare and Medicaid Services 2009). Reliance on MDS tended to limit the individuals included in the survey to those who had been in a facility for more than two weeks.

Summary of Major Findings

Observed improvements from 2008 to 2009 include the following:

- more individuals had treatment plans for repositioning to address risk factors for pressure ulcers,
- more care plans addressed risk factors for pressure ulcers,
- more individuals were assessed using a valid pain assessment tool and were assessed daily;
- more individuals received the influenza and pneumococcal vaccinations;
- more individuals received care consistent with advance directives;
- more advance care plans addressed artificial nutrition and hydration;
- more individuals were assessed for risk factors for weight loss and dehydration;

⁶⁶ The survey was performed by Nurse Aide Competency Evaluation Service Plus Foundation, Inc.

⁶⁷ Among the individuals who were sampled but did not participate because they were not at the facility at the time of the survey: 15 people were on pass, ten people were discharged, 20 people were in the hospital, two people were at physician appointments, and three people were deceased.

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- more individuals had clinical indications for prescribed typical antipsychotics; and
- more individuals felt safe and secure and that their possessions were safe.

Observed declines from 2008 to 2009 include:

- fewer individuals diagnosed with an anxiety disorder had an ongoing symptom assessment every two weeks,
- fewer individuals could make a private phone call, and
- fewer individuals could find a place to visit in private.

II. DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES (DARS)

Division for Blind Services (DBS) Customer Service Survey

Purpose

The purpose of this report is to present the results of a telephone-based consumer satisfaction survey conducted on a quarterly basis during state fiscal year 2009 (SFY2009) with individuals completing the program of services in the Vocational Rehabilitation, Independent Living, or Blind Children’s Vocational Discovery and Development programs. Services may have been initiated in SFY2009 or before. Specifically, the intent of this report is to assess the level of consumer satisfaction in terms of:

- interaction with DBS staff, and
- the quality and effectiveness of the services they receive.

Sample

To be eligible for inclusion in the survey, the consumer’s case must have been closed (either successfully or unsuccessfully) after receiving services under a plan of services during SFY2009. Services may have been initiated in SFY2009 or before. This criterion was chosen to ensure that consumers fully understood the scope of the program and the intent of services at the time they were surveyed.

Because of the relatively small size of these programs, attempts were made to contact each eligible consumer rather than selecting only a sample, of the total population. No target was established in terms of the total number of surveys completed.

The surveys were conducted by phone to increase the percentage of consumers responding to the survey. This is particularly important to the specific population served by the Division for Blind Services, since most consumers have difficulty reading printed material and would be less likely to respond to a survey sent by mail.

The response rate for each of the programs was approximately 50 percent. There were 1,549 completed surveys:

- 868 from Vocational Rehabilitation program consumers,
- 590 from Independent Living program consumers, and
- 91 from Blind Children’s Vocational Discovery and Development program consumers (or their families).

Summary of Major Findings

For each of the three programs, an independent contractor contacted consumers via telephone and asked them a series of eleven questions. Below are some of the major findings for each program.

Vocational Rehabilitation Program. Of the 868 consumers surveyed:

- 97.9 percent reported their overall experience with the Division for Blind Services as satisfactory or very satisfactory.
- 99.5 percent reported they were treated with courtesy and respect by DBS staff.
- 99.2 percent reported they had increased skills and abilities because of the assistance received from the Division for Blind Services.
- 98.8 percent reported the services were provided in a reasonable amount of time.

Independent Living Program. Of the 590 consumers surveyed:

- 99.7 percent reported their overall experience with the Division for Blind Services as satisfactory or very satisfactory.
- 100 percent reported they were treated with courtesy and respect by DBS staff.
- 99.5 percent reported they could do more in and around the home because of services provided by the Division for Blind Services.
- 99.7 percent reported the services were provided in a reasonable amount of time.

Blind Children’s Vocational Discovery and Development Program. Of the 91 consumers surveyed:

- 96.7 percent reported their overall experience with the Division for Blind Services as satisfactory or very satisfactory.
- 97.8 percent reported they were treated with courtesy and respect by DBS staff.
- 97.8 percent reported they had increased skills and abilities because of the assistance received from the Division for Blind Services.
- 97.8 percent reported the services were provided in a reasonable amount of time.

Division Rehabilitation Services (DRS): Vocational Rehabilitation Consumer Satisfaction Survey

Purpose

The purpose of this report is to present the state fiscal year 2008 (SFY2008) and state fiscal year 2009 (SFY2009) results of an ongoing customer satisfaction survey of vocational rehabilitation consumers whose cases were closed. More specifically the intent of this report is to:

- provide DRS management and staff ongoing feedback from vocational rehabilitation consumers in order to identify strengths and weaknesses, to develop strategies on providing excellent services to consumers and to determine areas of needed improvement;
- comply with the federal program requirements for the vocational rehabilitation (VR) program to have a survey mechanism in place to obtain satisfaction feedback from its consumers; and
- provide the state rehabilitation council (the Rehabilitation Council of Texas) regular reports to assist it in fulfilling its requirements to review and analyze consumer satisfaction with VR agency functions, VR services provided by DRS, and employment outcomes achieved by eligible individuals served by VR.

Sample

All vocational rehabilitation consumers whose cases were closed “successful” or “unsuccessful” with a plan are eligible to participate in this ongoing survey. This criterion was chosen as these consumers were more likely to understand the scope of the program and the intent of services at the time they were surveyed. This report presents the results for vocational rehabilitation consumers whose cases were closed “successful” or “unsuccessful” with a plan during SFY2008 and SFY2009.

In both SFY2008 and SFY2009, attempts were made to contact each eligible consumer in the above referenced group rather than selecting a sample. The entire population was selected in order to afford each consumer an opportunity to provide feedback focused on improving DRS services.

SFY2008 VR Consumer Satisfaction Survey. A total of 14,736 vocational rehabilitation closure records in SFY2008 were eligible to be contacted. Several attempts via telephone were made to reach each member of the eligible sample group during the month following the case closure. From the pool of closure records, 7,605 surveys were completed for a response rate of 51.6 percent. Per the terms of the contract, the vendor reported only on completed surveys and did not report on consumers who refused to complete the survey or consumers the vendor could not locate.

SFY2009 VR Consumer Satisfaction Survey. A total of 13,605 vocational rehabilitation closure records in SFY2009 were eligible to be contacted. Several attempts via telephone were made to reach each member of the eligible sample group during the month following the case closure. From the pool of closure records, 6,542 surveys were completed for a response rate of 48.1 percent. Per the terms of the contract, the vendor reported only on completed surveys and did not report on consumers who refused to complete the survey or consumers the vendor could not locate.

Summary of Major Findings

An independent contractor contacted consumers via telephone and asked them eighteen questions.⁶⁸ The instrument used for the 2008 and 2009 Vocational Rehabilitation Consumer Satisfaction Surveys contained the same eighteen questions used in the 2006 and 2007 surveys.⁶⁹ Below are the major findings for the SFY2008 and SFY2009 surveys.

SFY2008 VR Consumer Satisfaction Survey.

- For DRS consumers, the percentage who were very satisfied with their job in SFY2006 (52.5 percent), SFY2007 (54.9 percent), and SFY2008 (57.1 percent) exceeded the percentage in the completely satisfied category of the Gallup poll for all years. The combined total of very satisfied and satisfied in SFY2006 (86.1 percent), SFY2007 (87.3 percent), and SFY2008 (88.9 percent) were somewhat lower than the corresponding combined totals for completely satisfied and somewhat satisfied in the Gallup survey for the corresponding years. The difference of seven percent in SFY2007 narrowed to less than two percent in SFY2008. This comparison provides support for a conclusion that the rate of job satisfaction among DRS closed consumers is similar to the rate of job satisfaction in the general workforce, as reported in the Gallup survey.
- Consumers were asked the open-ended question, “What could DRS do to improve services”. The theme that occurred most frequently in the SFY2008 responses concerned policy and procedures issues (21.8 percent), service issues – employment (18.4 percent), service issues – other (10.7 percent), service issues – training (10.4 percent), and client information needs (9.4 percent). This matched the five highest categories in the 2007 survey, in the same order. In the category of policy and procedure issues, the speed with which services were delivered, the length of time services were provided, and the range of service alternatives were issues frequently identified by respondents.
- Compared to the SFY2007 survey results, in SFY2008 there was a two percent decrease in consumers reporting that their phone calls to DRS were returned, identifying a possible need for procedural changes in some DRS offices.

⁶⁸ PVT DataSource is the contracted vendor for administering the survey. The University of Texas School of Social Work analyzed and reported on the survey results.

⁶⁹ The instrument consisted of seventeen close-ended questions and one open-ended question.

- In SFY2008 there was a 2.9 percent decrease in respondents reporting that they took part in choosing who would provide services as compared to SFY2007 results. Since informed consumer choice is an important component of VR service delivery, this was another area of focus for management.
- Compared to the SFY2007 survey, in SFY2008 there was a 4.4 percent decrease in consumers reporting that they were working at the time of the survey, but there were increases in satisfaction with wages, employee benefits and chance for advancement for those who had jobs.

SFY2009 VR Consumer Satisfaction Survey. Note: The final analysis report has not yet been received as Gallup numbers are not yet available for comparison purposes at the time of this report. However, a draft analysis report reveals some of the following findings.

- Consumers were asked the open-ended question, “What could DRS do to improve services.” The theme that occurred most frequently in the 2009 responses concerned service issues – employment (18.3 percent), policy and procedure issues (12.1 percent, vocational rehabilitation counselor interpersonal skills (11.7 percent), service issues – other (10.6 percent), client contact issues – other (9.9 percent). This was a change from the top five issues identified in the SFY2008 survey. Within the category of service issues – employment, respondents often mentioned that they wanted better jobs, at better rates of pay, and found within a shorter time frame.
- Compared to the SFY2008 survey, in SFY2009 there was a 6.7 percent increase in respondents expressing satisfaction with job security.
- Compared to the SFY2008 survey, in SFY2009 there was a small increase in the percentage of respondents reporting that they took part in choosing who would provide services, an area of ongoing focus for DRS pertaining to informed consumer choice.
- Consumer satisfaction with employee benefits and the length of time it took to receive services decreased from SFY2008 to SFY2009.

Division Rehabilitation Services (DRS): Independent Living Services Consumer Satisfaction Survey

Purpose

The purpose of this report is to present the state fiscal year 2008 (SFY2008) results of an ongoing customer satisfaction survey of independent living consumers whose cases were closed. More specifically the intent of this report is to:

- provide DRS management and staff ongoing feedback from Independent Living Services consumers in order to identify strengths and weaknesses, to develop strategies on

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providing excellent services to consumers and to determine areas of needed improvement;

- comply with the federal program requirements for the Independent Living Services program to have a survey mechanism in place to obtain satisfaction feedback from its consumers; and
- provide the State Independent Living Council information to assist it in fulfilling its requirements to review and analyze consumer satisfaction with DRS' Independent Living Services program.

Sample

All Independent Living Services consumers whose cases were closed “successful” or “unsuccessful” with a plan are eligible to participate in this ongoing survey. This report presents the results for Independent Living Services consumers whose cases were closed in SFY2008.

Attempts were made to contact each eligible consumer in the above referenced group rather than selecting a sample. The entire population was selected in order to afford each consumer an opportunity to provide feedback focused on improving DRS services.

A total of 715 Independent Living Services closure records in SFY2008 were eligible to be contacted. Several attempts via telephone were made to reach each member of the eligible sample group during the month following the case closure. From the pool of closure records, 476 surveys were completed for a response rate of 66.6 percent.

Summary of Major Findings

An independent contractor contacted consumers via telephone and asked them fifteen questions.⁷⁰ The instrument used for the 2008 Independent Living Consumer Satisfaction Surveys contained the same fifteen questions used in the 2006 and 2007 surveys. Below are the major findings for the SFY2008 survey.

- In comparing responses in the 2008 Independent Living Services survey with the 2007 survey, there was an increase in consumer satisfaction ranging from a low of 0.5 percent more satisfied to a high of 6.4 percent more satisfied.
- Four questions showed increases in satisfaction greater than five percent from 2007 to 2008:
 - My DRS Independent Living counselor gave me choices (5.9 percent).
 - As a result of the services I received, I can do more in the community, if I want to (6.4 percent).

⁷⁰ PVT DataSource is the contracted vendor for administering the survey. The University of Texas School of Social Work analyzed and reported on the survey results.

- I took part in choosing who would provide services (5.7 percent).
- I was satisfied with how long it took to provide the services (6.3 percent).
- Consumers were asked the open-ended question, “What did you *like most* about your experience with DRS”. These same four items were the top four items in 2006 and 2007. The results were that DRS was:
 - helpful (21.8 percent),
 - responsive (8.8 percent),
 - treated the customer courteously (18.7 percent), and
 - services were liked (16.6 percent).
- Consumers reported dissatisfaction with the timeliness of services (15.3 percent), when asked the open-ended question, “What did you *dislike* about your experience with DRS”. Timeliness of services was also the issue most often mentioned on the 2006 and 2007 surveys.

Early Childhood Intervention (ECI) Family Survey Results SFY2009

Purpose

The purpose of this report is to present the results of the Family Outcomes Survey, a mail-based family survey conducted from February through March 2009 with the parents of children enrolled in the DARS Early Childhood Intervention (ECI) program in Texas during state fiscal year 2009 (SFY2009). The ECI program serves families with children birth to 36 months with developmental delays or disabilities through a statewide system of community-based programs. The ECI Family Outcomes Survey assesses family perceptions of services. More specifically, the intent of this report is to describe:

- families’ reporting of how helpful services are for them and their child enrolled in the ECI program;
- families’ reported ability to access other services and supports; and
- families’ reported competencies in helping their child develop and learn.

Sample

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To be eligible for inclusion in the sample, children had to be enrolled in the ECI program for at least six months during SFY2009. This criterion was chosen to ensure that the family had sufficient experience with the program to respond to the questions.

A target was set of 470 completed mail surveys. The sample size was selected to provide a reasonable confidence interval for the survey responses. A multi-stage stratified random sampling plan was used to select the sample. The 58 local ECI programs were stratified with respect to geographic region and size, and 29 programs were randomly selected from the strata. Then, a random sample of families was proportionately selected from each of the 29 programs.

Attempts were made to contact 1,345 families. Surveys were given to families by service coordinators employed at local programs, and they were returned directly via mail to the ECI state office. Using this method of contact, 1,240 families (92 percent) of families were given a survey. Of the 1,240 families who received the Family Outcomes Survey, 604 returned the survey, yielding a response rate of 48.7 percent.

Summary of Major Findings

- Analyses indicate that SFY2009 respondents were representative of the statewide population of families in the ECI program in terms of age, race/ethnicity and geographic region.
- Overall in SFY2009, 89 percent of families reported that early intervention services helped them effectively communicate their children's needs. This is the same percentage of families who reported this in SFY2008. There was some variation across local programs in SFY2009. The range of results was from 71 percent to 100 percent.
- Overall, 91 percent of families reported that early intervention services helped them help their children develop and learn. This is the same percentage as in SFY2008. In fiscal year 2009, the range of results across local programs was from 71 percent to 100 percent.
- Overall, 85 percent of families reported that early intervention services helped them know their rights. This is slightly higher than the 83 percent of families who reported this in fiscal year 2008, but still within sampling error. The slightly lower result for this indicator compared to others could be due in part to the more abstract nature of the construct.
- The percentage of families who reported that they were comfortable participating in service planning meetings with service providers was 89 percent, comparable to 88 percent reported in fiscal year 2008.
- Families reported their own knowledge and understanding of their child's strengths, abilities and special needs. Eighty-five percent of families reported that they understood their child's development, 83 percent reported understanding their child's special needs, and 92 percent indicated that they were able to tell if their child was making developmental progress.

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- There were various degrees of satisfaction with access to other resources in their communities. Overall, 90 percent of families reported that their family’s medical care met their child’s special needs and 71 percent of families indicated that they had child care to meet their child’s needs. Fifty-two percent of families reported that their child was able to participate in community and/or social activities. Overall, 53 percent of families said they were prepared for transition when their child leaves early intervention services.

III. DEPARTMENT OF FAMILY PROTECTIVE SERVICES (DFPS)

Adult Protective Services Community Satisfaction Survey

Purpose

The purpose of this report is to present the results of the online and mail-based 2009 Texas Adult Protective Services Community Satisfaction Survey conducted in May 2009 with members of the Judiciary, law enforcement agencies, community organizations and resource groups, and Adult Protective Services (APS) Community Boards. The Texas Department of Family and Protective Services (DFPS) develops an annual community satisfaction survey in accordance with Human Resource Code, Section 48.006. The purpose is to solicit information regarding DFPS performance in providing investigative and adult protective services. The 2009 survey is the fifth survey conducted concerning community satisfaction about adult protective services. APS uses results of the annual surveys to assess overall community engagement efforts. Specifically, the results:

- offer direction for sustaining community support and planning local community engagement initiatives to strengthen volunteer programs and enhance community resources that benefit APS clients.

Sample

To be eligible for inclusion in the sample, a person had to be identified by regional or local APS staff as someone who had a working relationship with the APS program and belonging to one of the following stakeholder groups: person in the judicial system (including county judges, district and county attorneys), law enforcement personnel, community organizations and resource groups (such as service providers and Area Agencies on Aging), and APS Community Board members.

The 2009 survey was sent to 2,227 stakeholders. There were 381 surveys returned for an overall response rate of 17 percent, a ten percentage point decrease from the 2008 survey. The response rate decreased for all four stakeholder groups.⁷¹

APS administered the survey in a web-based format using SurveyMonkey, an online survey development tool. An electronic message was sent to potential respondents with instructions for accessing and completing the online survey. Individuals without access to the Internet were provided a paper copy via fax or mail.

⁷¹ Surveys returned after the June 1st deadline were excluded from the data analysis. However, APS sent the comments from all of the surveys to the regions for evaluation and implementation of changes necessary to address community concerns.

Summary of Major Findings

HHSC worked with APS and a community relations workgroup to design four separate surveys for the diverse community organizations with whom APS interacts. The surveys were administered to 1) members of the Judiciary, 2) law enforcement agencies, 3) community organizations, and 4) APS community boards. Surveys were available online or in paper copy format. In preparation for the 2009 survey, APS regional management and community engagement specialists reviewed the 2008 survey items. No changes were made to the survey questions, and so comparisons can be made between the 2007, 2008 and 2009 results.

The 2009 questionnaire consisted of Likert scale statements and open-ended questions that measured the extent of respondent awareness of APS involvement in the community and perceptions of APS staff capability, effectiveness, and professionalism. Below are the major findings.

- Overall, the 2009 Community Satisfaction Survey results from all four stakeholder groups were positive. A majority of respondents indicated they “Strongly Agreed” or “Agreed” with all topics regarding APS performance. The percentage of agreement decreased between 2007 and 2009 for several questions in each of the four surveys.
- All stakeholder groups indicated their level of agreement with the statement, “APS ensures the safety and dignity of vulnerable adults in this community.” Community Board respondents had the highest level of agreement with 95 percent indicating they either “Strongly Agreed” or “Agreed” with the statement. Community Organizations and Law Enforcement had the next highest levels of agreement (87 percent and 79 percent respectively). The Judiciary had the lowest level of agreement (64 percent). A sizable majority of respondents in all four stakeholder groups responded to this statement with “Strongly Agreed” or “Agreed.”
- All stakeholder groups indicated their level of agreement with the statement, “There is a good working relationship between [the survey group] and APS in this community.” Community Organization respondents indicated the highest levels of agreement (83 percent). The Community Board respondents reported the next highest levels of agreement (81 percent). Among Law Enforcement and Judiciary respondents, 74 percent and 76 percent indicated they “Strongly Agreed” or “Agreed” with the statement. Historically, Law Enforcement and the Judiciary respondents have lower levels of agreement when compared to Community Organization and Community Board stakeholder groups.
- Community Board Members, Community Organizations, and Law Enforcement were asked to indicate their levels of agreement with the statement, “I understand APS’ mission, scope, and purpose.” Community Board Members and Community Organizations reported high levels of agreement (97 percent and 95 percent respectively). Law Enforcement respondents reported less agreement (70 percent), but still represented a sizeable majority.

For more information, a full copy of this report is available at:

http://www.dfps.state.tx.us/documents/about/pdf/2009-12-03_CommSatisfSurveyReport.pdf

Improving the Quality of Services to Youth in Substitute Care: A Report on Surveyed Youth in Foster Care FY 2007, Texas Department of Family and Protective Services, September 2008

Purpose

The purpose of the research was to provide information from youth in foster care to stakeholders (including community partners, Child Protective Services management and staff, and adolescents served by CPS) to encourage continual improvements in the foster care program. The report includes:

- the 2007 results of two surveys of youth in foster care (the Annual Random Youth Survey and the Youth Questionnaire), and
- a description of CPS's ongoing efforts toward program improvement.

Annual Random Youth Survey

The Annual Random Youth Survey, mandated by Texas Legislature, is an annual telephone-based survey conducted between July and October 2007 with youth ages 14 to 17 receiving foster care services on or during April 30, 2007.⁷² The survey measures respondents' views of the services provided to them in preparation for adult living, including the quality of the substitute care services provided to them, any improvements to support youth in care, and additional factors DFPS considers relevant to program enhancement.

Sample

A random sample of youth who received foster care services on or during April 30, 2007 were included in this survey. This criterion was chosen to provide information from youth in foster care to stakeholders (including community partners, Child Protective Services management and staff, and adolescents served by CPS) to encourage continual improvements in the foster care program.

A target was set of 362 completed surveys. This sample size was selected to have an accuracy of ± 5 percent within a 95 percent confidence interval.

Youth specialists in each region were supplied a randomized list of all youth 14-17 years old in their region to contact for interviews. The specialists began with the first name on their list and conducted interviews with successive youth on the list until their target of 33 interviews was completed. When contacted youth refused to participate or were otherwise unable to participate, that youth was skipped and the next consecutive youth on the list was contacted. The youth

⁷² Senate Bill 6, 79th Texas Legislature, 2005.

specialists completed 373 interviews. No data are available to document percent refusal or those unable to participate.

Summary of Major Findings

The Annual Random Youth Survey results address three categories of substitute care services the youth may have used while in foster care: support services, financial benefits and the adoption process.

Support Services.

- A high percentage of respondents rated the quality of the following support services as “good” to “outstanding”: personal and interpersonal skills (83 percent of respondents), job skills (85 percent), housing and transportation (84 percent), health (89 percent), planning for the future (83 percent), money management (76 percent), counseling/therapy (82 percent), and mentoring (83 percent).
- High school youth received additional support services. A high percentage of respondents rated the quality of the following additional support services as “good” to “outstanding”: vocational assessment (79 percent), GED classes (76 percent), preparation for college exams (81 percent), driver’s education (84 percent), and high school graduation expenses (84 percent).

Financial Benefits.

- Respondents were eligible to receive financial benefits through the Educational and Training Voucher Program and The Texas Youth Hotline. The responses indicated that approximately 55 percent were aware of the services, but only 8.5 percent had actually received them.

Adoption Process.

- Twenty percent of the respondents indicated that they had participated in the adoption process. Of those, 32 percent rated the experience as being “poor” to “very poor”, 35 percent rated it as “adequate”, and 33 percent rated it as “good” to “very good”. These findings are an improvement from the FY2006 survey, where most comments indicated the process was too slow or no placement resulted. However, one-third of the youth still found the process lacking.

Youth Questionnaire

The Youth Questionnaire, created by alumni of the Texas foster care system and CPS staff, is part of an ongoing effort to obtain feedback from youth being discharged from foster care. This report presents the result of self-administered surveys received from youth who exited care in the latter half of State Fiscal Year 2006 (SFY2006) and State Fiscal Year 2007 (SFY2007). The questionnaire obtains feedback about the quality of the youth’s most recent foster care placement

and how the placement helped prepare them for adult living. Completion of the Youth Questionnaire is optional.

Sample

The optional Youth Questionnaire is a survey that youth are asked to complete as part of the foster care discharge process. The questionnaire is strictly voluntary and is generally distributed to the youth during discharge. The questionnaire was distributed to youth who exited care in the latter half of SFY2006 and SFY2007 (March 2006 through August 2007).

Data are not available to determine the number of youth asked to complete survey in the latter half of SFY2006 and SFY2007. The questionnaire was returned by 228 youth. Of the 143 youth who provided their age, eighty-five percent were 18 years of age or older.

Summary of Major Findings

The questionnaire provided an opportunity for youth to comment on the quality of their most recent placement and how it helped prepare them for adult living with the primary focus on those who assisted youth in foster care rather than the services received while in care.

- Sixty-nine percent of the responses received from the exit survey indicated that youth were either “satisfied” or “extremely satisfied” with their last placement.
- Seventy-five percent preferred a foster home placement rather than a group home placement.
- Seventy-one percent rated their last placement as being helpful in dealing with problems, while 73 percent indicated that the last placement was helpful in preparing them for adult living.

Combined Major Findings

Both the Annual Random Youth Survey and the Youth Questionnaire indicate that youth are generally satisfied with the quality of all services and benefits made available to them. However, comments made in the qualitative sections suggest that there are areas of improvement still needed within the program for service enhancement. Based on youth comments, areas for improvement include:

- an increase in their caseworker time and attention;
- lowered caseloads to accommodate more access to their caseworker;
- more information about all their options;
- more responsiveness from caseworkers when voicing concerns and opinions;

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- more advice from adults (caseworkers, counselors and mentors, etc.) in order to make their own informed decisions;
- increased training to prepare them for adult living; and
- improved understanding of the process for securing financial benefits.

For more information, a full copy of this report is available at:

http://www.dfps.state.tx.us/documents/Child_Protection/pdf/2008-09-01_Youth_Survey_Report.pdf.

IV. DEPARTMENT OF STATE HEALTH SERVICES (DSHS)

The Children with Special Health Care Needs (CSHCN) Services Program 2009 Parent Survey Report

Purpose

The purpose of this report was to present the results of focus groups and written parent surveys conducted from June 2008 through March 2009 with parents of children affiliated with the CSHCN Services Program at the time of the survey. The intent of the survey was to:

- describe demographic characteristics of survey respondents,
- assess the needs of parents and family members and the health care and related services they received, focusing on the Title V national and state performance measures,
- compare results based upon respondents' languages (English or Spanish) and Department of State Health Services (DSHS) Health Service Regions (HSR),
- assess results compared to national and state-level data from the 2001 and 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN); and
- identify potential future areas for Title V CSHCN activities in Texas.

Sample

Focus Groups. The focus groups used a convenience sample of individuals who were parents of children affiliated with the CSHCN Services Program at the time of the survey and asked to participate by CSHCN Services Program community-based services contractors in Austin, San Angelo, and Amarillo. There were very few participants and no statistical analysis of the data.

Parent Survey. The parent survey used a convenience sample of individuals affiliated with CSHCN Services Program community-based services contractors, with survey distribution during previously scheduled contractor family support group meetings and/or conferences.⁷³

Program staff obtained an enhanced parent response than had been achieved historically through less personal survey distribution methods by working with contractors to distribute surveys in “natural settings” of typically high parent attendance, focus, and interest. There were 501

⁷³ Parents participated in the survey because they attended an event where the survey was administered. These events were sponsored by either a CSHCN Services Program contractor or another community-based health or human services entity with which CSHCN Services Program contractors or regional staff had close working relationships. Therefore, it is likely that parent survey participants were “known” by or knew about the Title V CSHCN Services Program, and their children may have been clients, applicants, or prospective applicants of the program.

completed surveys, with 396 (79.1 percent) submitted in English, and 105 (20.9 percent) submitted in Spanish.

Responses were distributed across the Health Service Regions (HSRs), except there were no responses from HSR 11 (Harlingen, Corpus Christi, and the Rio Grande Valley). This occurred primarily because there was limited contractor penetration in HSR 11, and there was a lack of contractor-sponsored activities during the data collection period. The largest number of respondents (24.8 percent, n=117) was from HSR 10 (El Paso), and there were 29 responses that did not contain enough geographic data to determine HSR.

Summary of Major Findings

Focus Groups. In conducting the focus groups, staff shared background information concerning Title V national and state performance measures and asked parents to talk about services that worked well for them and services that were not working well.

- When describing services that worked well, parents typically complimented the providers and individuals that have helped them access care and those with whom parents were most well-acquainted. Parents indicated that providers want to incorporate families in decision making, try to satisfy families, and at least in some ways, seek to give care that embraces many characteristics of a medical or health care home. Comments about services that worked well were less frequent than comments about services that were not working well.
- Among the services described as not working well, parents most often identified the following gaps and needs for services, programs, or providers:
 - Too much paperwork, difficult application forms, and an inadequate exchange of eligibility information among providers and others.
 - Too many programs that are complicated and difficult to understand or access; too little information about how to access the needed programs for which they qualify.
 - Not enough therapy or specialist providers; referrals are hard to get; reimbursement is poor; providers don't participate in all types of insurance plans (especially Medicaid); and there are very few adult providers for young adults with disabilities in transition.
 - Providers and others need training in caring for or giving services to children with special health care needs.
 - Insurance plans have confusing or unknown coverage limits and authorization requirements that are not well-suited for children and youth with special health care needs, such as no provisions for respite care, 'quality of life' services, or some equipment (hearing aids).

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- Too many case managers; each program has its own approach to case management with no one to coordinate across programs; and some program's case managers are not readily available (heavy caseloads and/or distance to offices).
- Mental health and substance abuse programs are unavailable or too limited in scope.
- Waiting lists for Medicaid Waiver (community-based) services are too long.

Parent Survey. The parent survey respondents were those who attended meetings or conferences where the survey was being conducted, and as such may differ from the general population of parents of children receiving special needs services. Below are findings from those surveyed.

- Nearly 80 percent of parents responding (n=395) reported that their doctor listens to them.
- Almost 90 percent of respondents (n=430) reported they can ask their doctor questions, and more than 8 percent (n=41) reported they can sometimes ask their child's doctor questions.
- More than 86 percent of parents (n=429) reported that their child sees the same doctor for regular care at most visits.
- In addition, 76 percent of parents (n=377) felt they can work with their doctor and make choices together about their child's care.
- One-third of respondents (33.2 percent, n=165) reported it is hard and an additional 20.1 percent (n=100) reported that it is sometimes hard to find specialists for their child.
- Less than two-thirds (62.4 percent, n=307) indicated that their child's doctor helps to find specialists or other services for their child.
- Of those responding yes or no to whether their child's doctor had asked the child (if 14 years of age or older) to talk about his/her own health care, the majority said no (52.4 percent, n=76).
- Overall, a majority of those responding (58.6 percent, n=275) have not thought about changing to a doctor who treats adults when their child is age 18 or older; however, a majority of respondents had children 10 years old or younger (56.2 percent, n=259). Among those with children 14 years of age and older (n=160), 42.5 percent (n=68) responded yes, 49.4 percent (n=79) responded no, and 8.1 percent (n=13) did not answer the question.
- Forty-two percent of respondents (n=199) reported that they got help finding health care, including equipment for their child. An additional 16.6 percent (N=79) indicated they sometimes got help. This complemented the 50.6 percent (N=250) who indicated they do not need help to get health care and equipment for their child.

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- Less than one-third (28.7 percent, n=142) indicated that they need help, and 15.7 percent (n=78) indicated they sometimes need help to get health care and equipment for their child. Of these, 65 (29.5 percent) said that they did not get or were not sure whether they had gotten help to find that care.
- Nearly one-third (29.0 percent, n=144) indicated that they need help and another 8.4 percent (n=42) indicated that they sometimes need help to get family support services, such as respite, van lifts, ramps, or changes to their homes, for their child.
- For those that indicated they needed help of any kind, only about one-third (33.8 percent, n=113) responded that they know how to get that help. An additional 12.2 percent (n=41) said they sometimes know how to get that help.
- When asked to indicate what services or products they or their child most needed, respondents most frequently indicated respite (25.6 percent, n=33), home modifications (21.7 percent, n=28), equipment (17.8 percent, n=23), and insurance/funding/Medicaid (10.1 percent, n=13). In addition, nearly 10 percent of those providing a response (9.3 percent, n=12) also indicated the need for providers.
- A majority of respondents (58 percent, n=288) reported that they planned that their child would live with them when the child becomes an adult, but of the 85 (17.1 percent) respondents who reported that their child will not live with them once the child becomes an adult, 48 (56.4 percent) reported their child will live independently, 7 (8.2 percent) reported in a group home, and 30 (35.3 percent) were unsure.

The Children with Special Health Care Needs (CSHCN) Services Program 2009 Provider Survey Report

Purpose

The purpose of this report was to present the results of an online survey conducted from March 2009 through May 2009, with health care providers for children with special health care needs. The intent of the survey was to:

- describe demographic characteristics of survey respondents;
- assess the extent that providers understood and demonstrated accord with the Texas Title V national and state performance measures for children and youth with special health care needs; and
- identify potential future areas for Title V CSHCN activities in Texas.

Sample

This survey used a convenience sample of providers recruited through announcements placed in the CSHCN Services Program *Provider Bulletin*, Remittance and Status Report banner messages,

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and website announcements; through Texas Pediatrics Society publications; through direct email to provider advocacy organizations, the statewide Medical Home Work Group, Texas Vaccines for Children providers and local health departments; and through DSHS School Health Program's *Friday Beat* online newsletter.

Of the 1,106 providers who viewed the survey, 686 began the survey. A total of 259 providers completed the survey for a completion rate of 37.76 percent.

The majority of respondents (51 percent, n=130) were practices focusing on children and adults. Forty-seven percent (n=121) were practices focusing on children only, and the remaining 2 percent (n=4) were practices focusing on adults only. The survey asked respondents to indicate whether they were the individual provider licensed as indicated or a staff member responding for the provider as indicated. More than one-half of respondents (59 percent, n=148) said they were the individual provider licensed as indicated.

While the survey neither sought nor obtained a statistically representative sample of providers serving children with special health care needs, the data describing the respondent population suggested that it was both geographically and professionally diverse.

Summary of Major Findings

The provider survey respondents were individuals that responded to recruitment announcements for the survey, and as such may differ from the population of health care providers for children with special health care needs. Below are findings from those surveyed.

- There were at least 16 respondents from each health service region (HSR), with more than one-half of the respondents coming from HSR 2/3 (Dallas-Fort Worth), HSR6/5S (Houston), and HSR 7 (Central Texas).
- Provider types included a large array of health professional and clinic designations. The practice specialties included a lot of variety; however, the largest single specialty category of respondent was pediatric physician (21 percent of all physicians and 6 percent of all respondents).
- One-quarter of respondents (25 percent, n=64) were CSHCN Services Program providers, but nearly three times as many (72 percent, n=186) were Texas Vaccines for Children (TVC) providers. About seventeen percent (n=43) were providers for both the CSHCN Services Program and TVC. While many CSHCN Services Program providers are TVC providers, there were many more TVC providers that are not currently enrolled as providers in the CSHCN Services Program.
- Among the nearly one-third (32 percent, n=82) of respondents who were unsure whether their practice or clinic was enrolled in the CSHCN Services Program, 22 were physicians (31 percent of physicians), 30 were nurses (39 percent of nurses), three were social workers (8 percent of social workers), and 27 were all other professions (36 percent of all other professions).

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- Overall, about 80 percent (n=205) indicated their practices encouraged and facilitated family involvement during office visits; however, fewer practices had characteristics that more intentionally engaged families and consumers.
- Two-thirds of respondents (66 percent, n=168) indicated their staff members were familiar with the basic characteristics of a medical home, but only 46 percent (n=117) reported that they considered their practices to be a medical home. Among the respondents who indicated they were CSHCN Services Program providers, a higher number considered their practices to be a medical home as compared with those that were not CSHCN Services Program providers.
- Overall, more than two-thirds (68 percent, n=172) reported they assisted families in finding health care insurance when needed, and this was especially true for nurses (75 percent of nurses responding, n=57) and social workers (89 percent of social workers responding, n=37). Further, more CSHCN Services Program providers reported assisting families in finding health care insurance than those that were not CSHCN Services Program providers.
- More than two-thirds (69 percent, n=175) of all respondents indicated their staff members were knowledgeable concerning health insurance resources in Texas. This was the case for 63 percent of physicians (n=44), 90 percent of social workers (n=32) and 86 percent of nurses (n=56). Even though considering themselves knowledgeable, nearly one-half (49 percent, n=123) of those responding reported experiencing difficulty finding health insurance resources.
- Many indicated their practices had ways to address cultural (77 percent, n=196) and transportation (58 percent, n=148) issues, but only 38 percent (n=98) indicated they had ways to address child care issues, if these issues were barriers to family involvement.
- About 85 percent (n=217) indicated they accommodated family members' special needs upon request, and slightly more than one-half (52 percent, n=132) indicated they asked families how to make practices more accessible.
- Twenty-one percent (n=55) reported that they had employees that were people with disabilities or family members of children or youth with special health care needs.
- Nearly three quarters (73 percent, n=184) indicated they helped families in finding community-based services and supports, but more than one-half (56 percent, n=142) said they experienced difficulty doing so.
- Overall, one-third (33 percent, n=84) of practices indicated they asked families to evaluate services and supports available in their communities.
- More than three-quarters of all respondents (76 percent, n=196) indicated they encouraged youth and young adults to take responsibility for their own care, but fewer (58 percent, n=146) indicated they discussed with youth, young adults, or their families

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planning for transition to providers serving adults. Among physician respondents alone, 87 percent (n=60) indicated they encouraged young adults to take responsibility for their own care, and 67 percent (n=45) said they discussed planning for transition to adult providers.

- Overall, about two-thirds (66 percent, n=169) reported they assisted young adult consumers to find health care providers serving adults or other health care transition services. Among those responding yes or no, 58 percent (n=105 of 180) reported experiencing difficulty finding those providers. About one-third of respondents (29 percent, n=75) indicated either don't know or not applicable to the question concerning whether their practice experienced difficulty finding providers serving adults.
- Forty percent (n=101) indicated their practices were familiar with transition services provided through area school districts; 35 percent (n=88) indicated they were familiar with transition services available through the Department of Assistive and Rehabilitative Services (DARS); and 24 percent (n=62) said they were familiar with DARS transition vocational rehabilitation specialists located in area high schools.
- More than one-half (54 percent, n=138) of all respondents indicated their practices were familiar with Medicaid and non-Medicaid community-based long-term care programs (e.g., Medicaid Waiver Programs, Personal Care Services, In-Home and Family Supports, etc.) and a like number (56 percent, n=143) indicated their practices helped link families to these programs.
- When asked whether their practices had ways to identify or determine the least restrictive environment in which patients can reside and receive services, only 37 percent (n=95) responded, "Yes." Twenty-one percent (n=53) said they had ways to follow up on patients who are placed in long-term institutional settings, and 22 percent (n=55) indicated they helped interested families to return home their children that live in long-term institutional settings. Nineteen percent (n=13) of physicians, 18 percent (n=14) of nurses, and 47 percent (n=17) of social workers, indicated they helped families in this way; however, CSHCN Services Program providers were more likely to report that their practices assisted in bringing home children that live in long-term institutional settings.
- Only 35 percent of all respondents (n=84 of 259) and 45 percent of respondents indicating they were CSHCN Services Program providers (n=30 of 64) reported that prior to receiving the information provided in this survey, they would rate their knowledge and understanding of the Texas performance measures as excellent/complete or good/average. A larger number of social workers indicated their knowledge was good/average or excellent/complete as compared with other professions; however, cell sizes were too small for statistical comparison among professions.
- There were 141 surveys that provided information in response to the question asking, "What is the single greatest unmet need of child or young adult consumers (ages 0-21) served by your practice?" The five needs mentioned most often were:
 - Access to care, services, and transportation.

- Availability of providers, including specialists, and dentists.
- Education and outreach to the public about services for children with special health care needs.
- Inadequate distribution of community-based social services and resources.
- Availability of family support and respite services.

The Children with Special Health Care Needs (CSHCN) Services Program 2009 Community Resource Coordination Groups Survey Report

Purpose

The purpose of this report was to present the results of an online survey conducted from March 2009 through April 2009, with participants in Community Resource Coordination Groups (CRCG) across Texas. The intent of the survey was to:

- describe demographic characteristics of survey respondents,
- assess the extent that CRCG participants understood and demonstrated accord with the Texas Title V national and state performance measures for children and youth with special health care needs, and
- identify potential future areas for Title V CSHCN activities in Texas.

Sample

This survey used a convenience sample of CRCG participants recruited through initial and reminder email announcements distributed by the Health and Human Services Office of Program Coordination for Children and Youth to all CRCG participants in Texas.

Of the 593 CRCGs that opened the survey, 400 started the survey. A total of 215 CRCG participants completed and submitted the survey for a completion rate of 53.75 percent. The CRCG Survey response approximates 10 percent of active participants in CRCGs statewide.

To characterize respondents, the survey asked the focus of the CRCG. The majority of respondents (54.5 percent, n=94) were from CRCGs serving children and adults. Forty-four percent (n=116) were from CRCGs serving children only, and 1.4 percent (n=3) of respondents were from CRCGs serving adults only. The data describing the respondent population suggested that it was both geographically and professionally diverse.

Summary of Major Findings

The CRCG participant survey respondents were individuals that responded to recruitment announcements for the survey, and as such may differ from the population of CRCG participants across Texas. Below are findings from those surveyed.

- There were at least 21 respondents from each health service region (HSR), with about one half of responses coming from HSR 2/3 (Dallas-Fort Worth), HSR 8 (San Antonio), and HSR 4/5N (East Texas).
- Respondents organizational affiliations included DSHS Staff serving children and youth with special health care needs (CYSHCN) (14 percent, n=30), , Mental Health and Mental Retardation (MH/MR) Centers including staff from DSHS and DADS (18 percent, n=39), Public Education (10 percent, n=21), Local Juvenile Probation Departments (23 percent, n=49), Private Sector individuals or entities (16 percent, n=23), and Affiliation Not Listed (19 percent, n=39).
- In general, respondents reported that their CRCGs facilitated cooperation with the families of children with special health care needs at all levels. Ninety-four percent (n=201) of respondents reported that their CRCGs routinely encouraged and facilitated family involvement at the family’s own service planning meetings, 86 percent (n=183) indicated they scheduled service planning meetings at times appropriate for families and consumers, and 56 percent (n=120) reported that their CRCGs oriented or trained their members about the value or importance of family input.
- Only 50 percent (n=107) of respondents reported that their CRCGs had knowledge about the basic characteristics of a primary care medical home, and 40 percent (n=84) said they experienced difficulty finding health care providers to be a medical home.
- Many respondents (78 percent, n=165) reported that their CRCGs were knowledgeable about and 68 percent (n=145) reported that they assisted their clients in finding health insurance, yet 48 percent (n=102) reported that they experienced difficulty in finding health insurance.
- Findings showed that CRCGs had ways to address transportation issues (71 percent, n=153), cultural issues (73 percent, n=155), and child care issues (54 percent, n=116), if they were barriers to family involvement.
- Over 85 percent (n=183) indicated they accommodated family members’ special needs upon request.
- Thirty-two percent (n=68) of those surveyed reported that family members were eligible to serve in leadership positions.
- In contrast with an apparently high level of support for family involvement, only 17 percent (n=37) of respondents said that their CRCGs regularly asked families to evaluate services and supports available in their communities; only 18 percent (n=39) surveyed

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consumers or their families to determine if they were satisfied with the services they receive from the CRCG; and only 32 percent (n=68) said their CRCGs regularly asked consumers or families how to make CRCGs more accessible to consumers or families.

- Sixty-three percent (n=134) said that their CRCGs assisted families and young adult consumers in finding health care providers serving adults or other health care transition services; however, 51 percent (n=108) reported that they experienced difficulty in finding these providers or services.
- More than 80 percent (n=176) of respondents reported they helped link families with Medicaid waiver and non-Medicaid community-based services programs; 75 percent (n=159) said they had ways to identify least-restrictive environments; 66 percent (n=139) said they were able to follow up on clients placed in institutional settings; and 47 percent (n=100) indicated they helped return home children living in institutionalized settings.
- There were 158 responses to an open-ended question asking, “What is the single greatest unmet need of child or young adult consumers (ages 0-21) served by your CRCG?” Responses revealed that the single greatest unmet need was for mental health or behavioral health services, facilities, and programs. Other important unmet needs included funding or resources for long-term residential treatment or placement; having services available within nearby or local communities; aspects of CRCG operations; and more providers.

V. HEALTH AND HUMAN SERVICES COMMISSION (HHSC)

The Children's Health Insurance Program (CHIP) in Texas: The Disenrollee Survey SFY2008

Purpose

This report details results from the 2008 Children's Health Insurance Program (CHIP) Disenrollee Survey for the state of Texas, prepared by the Institute for Child Health Policy (ICHP) at the University of Florida. This telephone-based survey was conducted from February 2008 through June 2008 with families of children recently disenrolled from CHIP in Texas. The purpose of this survey is to:

- provide a demographic profile of children recently disenrolled from CHIP and their families, and
- determine their reasons for disenrollment.

Sample

A random sample of families with children who were enrolled in CHIP in Texas for six months or longer; and who disenrolled from CHIP for at least three months prior to study were selected to participate in this survey.

A target sample was set of 600 completed surveys. This sample size was selected to provide a reasonable confidence interval for the survey responses, based on selected survey items with uniformly distributed responses.

Attempts were made to contact 3,259 families, and 34 percent of families could not be located. Among those located, 20 percent refused to participate. The response rate was 41 percent and the cooperation rate was 59 percent. There were 601 completed surveys.

Summary of Findings

Statistical comparisons of results with the 2006 CHIP Disenrollee Survey and the 2008 CHIP New Enrollee Survey were performed for all measures that remained constant between the two surveys, respectively. A multivariate analysis was also conducted to test the influence of selected program experience and parent attitude factors on disenrollment due to non-renewal. Below are the major findings from this analysis:

- Sixty-six percent of disenrollees were Hispanic, and 39 percent of parents surveyed had achieved less than a high school education. Hispanic parents were more likely than those

of other races/ethnicities to agree that CHIP asks for too much background paperwork in the renewal process, and to agree that “paying the premium was a waste of money” because their child was healthy and didn’t need medical care very often.

- The proportion of children with special healthcare needs (CSHCN) among CHIP disenrollees was 24 percent, which is greater than the 19 percent of CHSCN reported in the CHIP new enrollee population in 2008. Children who disenroll from CHIP are at risk for being uninsured. This is a concern for all children but particularly those with special health care needs.
- About one-third of CHIP disenrollees between two and 19 years of age were overweight. In multivariate analyses, being overweight was associated with disenrollment due to non-renewal.
- Nearly 90 percent of respondents gave the program a “good”, “very good,” or “excellent” rating. Exceptions that highlight areas for potential improvement include:
 - Forty-nine percent of respondents rated the quality of care received in the program as “excellent”, which represents a decrease since 2006 (62 percent).
 - In comparison with respondents in the 2008 CHIP New Enrollee Survey, parents of children recently disenrolled from CHIP were less likely to list convenience or good service as the “best thing” about the program.
- Ineligibility due to income represented the primary reason for disenrollment, either because family income was too high (28 percent) or because family income was too low and the child was switched to Medicaid (24 percent). Compared with 2006, a greater percentage of respondents listed dissatisfaction with their child’s healthcare provider, with the clinic or office setting where care was received, and with the monthly premium or the co-pay as reasons for disenrollment.
- Another common reason for disenrollment was that the parent could not or did not complete the renewal process (13 percent). Among those with experience in the renewal process, 12 percent responded that it was “more difficult than it needed to be”, compared with 6 percent of respondents in 2006. Multivariate analyses revealed that not being told about the renewal process at the time of enrollment and considering the monthly premium to be “too much” were statistically significant factors in disenrollment due to non-renewal.
- Thirty-nine percent of parents indicated they selected another insurance policy for their children. The two most common forms of insurance after disenrolling from CHIP were Medicaid (59 percent) and employer-based private insurance (27 percent).
 - Fourteen percent of former members did not have the same physician who had treated them in CHIP. Among them, 31 percent did not have a new physician.
 - The two most common reasons for non-insurance were that: (1) insurance was too expensive (59 percent); and (2) parents were waiting to get their child back into CHIP (50 percent).⁷⁴

⁷⁴ All assessments described were conducted by the Texas External Quality Review Organization, The Institute for Child Health Policy at the University of Florida.

The Children's Health Insurance Program (CHIP) in Texas: The Established Enrollee Survey Report SFY2008

Purpose

This report details results from the 2008 Children's Health Insurance Program (CHIP) Established Enrollee Survey for the State of Texas, prepared by the Institute for Child Health Policy (IHP) at the University of Florida. This telephone-based survey was conducted from February 2008 through August 2008 with families of children enrolled in CHIP in Texas for at least 9 months prior to the study period. The purpose of this survey is to:

- provide a demographic and health profile of children enrolled in CHIP,
- assess parents' experiences and satisfaction with their children's healthcare, and
- compare findings across the 17 health plans participating in CHIP during fiscal year 2007.

Sample

A stratified random sample of families with children enrolled in CHIP in Texas for at least 9 months prior to the study period (February 2008 through August 2008) were selected to participate. This criterion was chosen to ensure that the family had sufficient experience with the program to respond to the survey questions.

A target was set of 5,100 completed surveys. This sample size was selected to:(1) provide a reasonable confidence interval for the survey responses; and (2) ensure there was a sufficient sample size to allow for comparisons among health plans.

Attempts were made to contact 13,133 families, and 43 percent of families could not be located. Nineteen percent of those located refused to participate. The response rate was 63 percent and the cooperation rate was 77 percent. There were 4,863 completed surveys, representing members of the 17 health plans.

Summary of Findings

Findings regarding parents' experiences and satisfaction with their children's healthcare focused on Health and Human Services Commission (HHSC) Performance Dashboard Indicators for fiscal year 2007 and the CAHPS[®] Health Plan Survey composite measures. Results were compared statistically across health plans, and by child's race/ethnicity and special healthcare needs status. Below are the major findings from this analysis:

- Seventy-one percent of established enrollees were Hispanic, and 35 percent of parents surveyed had achieved less than a high school education. Children of Other, non-Hispanic races/ethnicities represented 5 percent of the sample, but had lower scores in access to urgent care, customer service, getting needed information, prescription medicines, and transition to adult healthcare.

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- The proportion of children with special healthcare needs (CSHCN) among CHIP established enrollees was 20 percent. Dependence on medications was the most prevalent special need (17 percent of the sample), while access to prescription medications was lower among CSHCN than among children with no special healthcare needs. It is likely that increased need for medications among CSHCN corresponds with more perceived barriers to access.
 - Twenty-eight percent of CHIP established enrollees between two and 19 years of age were overweight. This figure is considerably higher than national and Texas averages, and suggests a critical need for promotion of healthy weight in this population. While most health plans have some form of childhood obesity program, more effort can be made to ensure these programs are comprehensive.
 - Seventeen percent of children in the sample were in need of specialist care. Although the need for special medical equipment remained small, the percentage of families who needed medical equipment increased between 2006 (2.6 percent) and 2008 (3.5 percent).
 - Eighty-five percent of children had a personal doctor. Overall utilization was low, with 22 percent of parents reporting no personal doctor visits in the six months prior to the survey. High scores were observed for both the Doctor's Communication and Personal Doctors CAHPS composite measures (89.03 and 82.49, respectively).
 - Among the seven HHSC Performance Dashboard Indicators measuring access to care, the highest access was reported for urgent care (85 percent), while the lowest access was reported for being taken to the exam room within 15 minutes of one's appointment (41 percent). Good access to special therapies and to behavioral health treatment or counseling was also relatively low, at 70 percent and 62 percent, respectively.
 - Of the three CAHPS[®] composite measures that addressed access to care, two – Getting Needed Care and Getting Specialized Care – fell below the 75-point benchmark (74.32 and 65.07, respectively). The 75-point benchmark indicates that the family “usually” or “always” had a positive experience.
 - Parents reported positive experiences with other aspects of their children's care, as assessed by CAHPS[®] composite measures. Scores for Customer Service, Shared Decision-Making, Getting Needed Information, Prescription Medicines, Care Coordination, and Overall Ratings all fell above the 75-point benchmark.
 - Differences were observed among the 17 health plans for most healthcare experience and satisfaction measures.
 - Driscoll emerged as one of the most highly-rated health plans, having the highest percentage of members with good access to routine care and no delays for an approval. Driscoll also scored the highest for three CAHPS[®] composite measures – Getting Needed Care, Getting Care Quickly, and Prescription Medicines.
 - Seton scored the highest for the Doctor's Communication and Personal Doctor CAHPS[®] composite measures, although children covered by Seton were more likely than those of other health plans to have not visited their personal doctors in the six months prior to the survey.
 - Mercy scored the highest for the Customer Service, Getting Needed Information, and Overall Ratings CAHPS[®] composite measures.
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- Molina emerged as one of the lowest-rated health plans, scoring the lowest for all CAHPS® composite measures except Getting Care Quickly, Getting Specialized Services, and Care Coordination. Molina also had the lowest percentage of members with a personal doctor (68 percent). Molina is a new health plan serving CHIP in Texas, with a relatively low number of members. As the Molina health plan grows, efforts should be made to ensure that policies and practices for both the health plan and its providers are in compliance with state-wide standards.
 - Among parents of CSHCN age 11 years or older whose doctors treated only children, 12 percent indicated that someone had spoken with them about how to obtain or keep some type of health insurance as their child becomes an adult. This figure is lower than the 22 percent reported in the 2005/2006 National Survey of CSHCN.

The Children's Health Insurance Program (CHIP) in Texas: The New Enrollee Survey SFY2008

Purpose

This report details results from the 2008 Children's Health Insurance Program (CHIP) New Enrollee Survey for the state of Texas, prepared by the Institute for Child Health Policy (IHP) at the University of Florida. This telephone-based survey was conducted from February 2008 through May 2008 with families of children newly enrolled in CHIP in Texas. The purpose of this survey is to:

- provide a demographic profile of new CHIP members and their families,
- understand the experiences of families during the application and enrollment process, and
- assess healthcare utilization and access to care for new CHIP enrollees.

Sample

A random sample of families with children who were enrolled in CHIP in Texas for three months or less, and were not enrolled in CHIP in the prior fiscal year was selected to participate in this survey.

A target sample of 600 was set. The sample size was selected to provide a reasonable confidence interval for the survey responses. The sample was not stratified by health plans participating in CHIP or by any other criteria.

Attempts were made to contact 1,800 families, and 32 percent could not be located. Of those located, 14 percent refused to participate. The response rate was 62 percent and the cooperation rate was 81 percent. Six hundred completed surveys were collected by telephone survey researchers.

Summary of Findings

Statistical comparisons of results with the 2006 CHIP New Enrollee Survey were performed for all measures that remained constant between the two surveys. A multivariate analysis was also conducted to test the influence of selected program experience components on respondents' overall rating of the program. Below are the major findings from this analysis:

- Sixty-eight percent of new enrollees were Hispanic, representing an increase in the proportion of Hispanic new enrollees since 2006 (56 percent). Compared with respondents of other racial/ethnic groups, a greater proportion of Hispanics agreed with the statement: “I tried to see a provider but I was told I was not yet enrolled.” Hispanic respondents were also more likely to agree that paying the insurance premium was a “waste of money” since their child was healthy and did not need care. These findings present implications for communication between CHIP and beneficiaries, access to care, and utilization patterns among Hispanic members.
- The proportion of children with special health care needs (CSHCN) among CHIP new enrollees has decreased from 25 percent in 2006 to 19 percent in 2008. Dependence on medications was the most prevalent special need in this population.
- About one-third of CHIP new enrollees between two and 19 years of age were overweight, compared with a national average of 17 percent. This discrepancy suggests that the CHIP population will likely experience a disproportionate burden of overweight- and obesity-related diseases and complications, along with greater costs of health care, than those incurred by the general population.
- Respondents continue to report good experiences with the application and enrollment process and to express high opinions of the CHIP program. More than 92 percent of respondents rated the program as “good,” “very good,” or “excellent.” Exceptions that show areas for potential improvement include:
 - Sixty percent of respondents reported a waiting period of one month or longer to receive coverage for the child. During this period, only 64 percent of respondents indicated that they were kept well-informed of their child’s application status.
 - Among the 53 percent of respondents who attempted to contact the toll-free number, nearly 20 percent were unable to reach someone easily. The most common problems reported were a long period “on hold” (53 percent) and not having questions answered (25 percent).
 - Fifty-seven percent of respondents reported choosing their child’s HMO or health plan, which represents a decrease from 63 percent in 2006.
 - Four out of five respondents had been informed about the renewal period during the application process. This leaves about 20 percent of new enrollees who said they were not informed, introducing the possibility of involuntary disenrollment at the time of renewal.

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- Dental coverage emerged as the most frequent response when respondents were asked what other benefits should be included in CHIP. It remains unclear whether respondents were not aware of existing dental coverage or whether they believed it was not comprehensive enough for their children's needs.
 - The most frequently reported "worst" thing about CHIP in Texas was poor coverage, much of which may be related to access to physicians. More than one-third of respondents had to change their child's personal doctor after enrolling in CHIP. Among those respondents, nearly 40 percent had some issues finding a personal doctor who accepts CHIP.
 - Results from the multivariate analysis revealed that a high program rating of CHIP ("Excellent" or "Very Good") was most likely among respondents who reported:
 - They were informed about their child's application status;
 - They were able to reach a helpful person at the toll-free number; and
 - They chose their child's HMO/health plan.

Texas STAR+PLUS Enrollee Survey Report Fiscal Year 2009

Purpose

This report provides results from the 2009 STAR+PLUS Enrollee Survey for the State of Texas, prepared by the Institute for Child Health Policy (IHP) at the University of Florida. This telephone-based survey was conducted from December 2008 through April 2009 with individuals enrolled in the Texas Medicaid STAR+PLUS Program for at least 9 consecutive months between September 2007 and August 2008⁷⁵. The purpose of this survey is to:

- provide a demographic and health profile of STAR+PLUS members,
- document healthy behaviors and health promotion activities, and
- assess enrollees' experiences and satisfaction with getting urgent, routine, and specialty care and care coordination services.

Sample

A random sample of individuals enrolled in the Texas STAR+PLUS Program were targeted to participate in this survey. Specifically a person had to meet the following criteria:

- enrolled in STAR+PLUS for at least nine consecutive months between September 2007 and August 2008,
- age 18 or older during their eligibility period,
- eligible for Medicaid, but not for both Medicaid and Medicare, and

⁷⁵ STAR+PLUS is a Texas Medicaid managed care program designed to provide health care, acute and long-term services and support through a managed care system. <http://www.hhsc.state.tx.us/starplus/Overview.htm>. Last viewed 5/21/10.

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- did not participate in the prior year's STAR+PLUS survey.

A target sample of 300 completed surveys for each of the four participating STAR+PLUS health plans in Texas was set. This sample size was selected to provide a reasonable confidence interval for the survey responses, based on selected survey items with uniformly distributed responses.

Attempts were made to contact 8,047 individuals. Using the contact information provided, 52 percent of individuals could not be located. Among those located, nine percent refused to participate. The response rate was 53 percent and the cooperation rate was 78 percent. The total number of completed surveys for all four health plans was 1,201.

Summary of Findings

Descriptive analyses were conducted on all survey questions. Statistical tests of differences between relevant subgroups and between SFY2008 and SFY2009 survey data were performed. Multivariate analyses were also conducted to test the influence of several individual factors on health care satisfaction. Below are the major findings from this analysis:

- **Demographics.** Forty-one percent of STAR+PLUS survey respondents were Hispanic, 47 percent had less than a high school education, 69 percent were female, and 82 percent primarily spoke English. The average age of survey respondents was 50 years old.
- **Housing and employment.** Approximately half of survey respondents answered questions dealing with housing and employment. Among these enrollees, nearly half lived in rented housing and one-quarter lived in their own home. Ninety-three percent had not worked in the six months prior to the survey. The most frequently cited reasons for being unable to work included: (1) deterioration of health resulting from work (69 percent somewhat or strongly agreed); (2) work being too stressful (48 percent somewhat or strongly agreed); (3) being unable to find a job that meets the enrollee's needs (40 percent somewhat or strongly agreed); and (4) being unable to find a job that provided needed special accommodations (40 percent somewhat or strongly agreed).
- **Health status.** Overall, STAR+PLUS enrollees had low health status scores, particularly regarding role limitations due to physical health and energy/fatigue. Nearly one-third (30 percent) of respondents rated their overall health as "poor", while only seven percent rated their overall health as "excellent". One-third of respondents said they needed the help of others for simple activities of daily living (such as eating or dressing) because of an impairment or health problem.
- **Health promotion.** Two-thirds of respondents said they had a routine checkup with a doctor during the year prior to the survey. Rates of overweight and obesity among STAR+PLUS enrollees were high, with 77 percent of respondents being either overweight or obese. Nearly half (49 percent) said they had received a flu shot since September 1, 2008 – an increase over the 39 percent of SFY2008 respondents who reported receiving a flu shot since September 1, 2007. Thirty-five percent of respondents said they smoked either some days or every day. Among those who reported smoking, on at least one visit with their doctor or other health provider, 63 percent had been advised to quit smoking, 34 percent had been recommended medication to assist in quitting

smoking, and 34 percent had been recommended other strategies to assist in quitting smoking.

- **Personal doctor.** The majority of STAR+PLUS enrollees had a personal doctor (87 percent). Continuity of care was good, with 64 percent of those who had personal doctors reporting being in their doctor's care for two years or longer. When calling their doctors' offices for advice or help, most enrollees usually or always got the help they needed, regardless of whether enrollees reported calling their personal doctors during office hours (73 percent got help) or after office hours (70 percent got help). Among enrollees who did not have the same personal doctor before they joined the program, 45 percent said it was always easy to find a personal doctor they were happy with.
- **Urgent and routine care.** Experiences with getting care were more positive than in the prior year's survey. Eighty percent of STAR+PLUS enrollees were usually or always able to get urgent care as soon as they needed, compared with 73 percent among SFY2008 respondents. Seventy-seven percent of STAR+PLUS enrollees were usually or always able to get appointments for routine care as soon as they thought they needed, compared with 71 percent in SFY2008.
- **Health care delays.** Overall, STAR+PLUS enrollees experienced few delays in receiving health care. Forty-four percent of survey respondents reported never having delays for health plan approval of their care, which was statistically significantly greater than the 33 percent reported among SFY2008 survey respondents. Seventy percent of STAR+PLUS enrollees said that they were able to see a provider within one week of making an appointment. Forty-four percent of respondents reported usually or always being taken to the exam room within 15 minutes of their appointment.
- **Specialist care.** Slightly less than half of the STAR+PLUS enrollees (45 percent) said they tried to make an appointment with a specialist. Among those who tried to make specialist appointments, 66 percent found it was usually or always easy to get a referral and 68 percent found it was usually or always easy to get an appointment.
- **Specialized services.** Between one-quarter and one-third of STAR+PLUS enrollees needed specialized services, such as special medical equipment (36 percent), special therapies (22 percent), or home health care (29 percent) during the six months prior to the survey. Compared with SFY2008 respondents, a greater percentage of STAR+PLUS enrollees said it was always easy to get medical equipment (51 percent vs. 41 percent) and special therapies (50 percent vs. 36 percent).
- **Mental health care.** Nearly one-quarter (24 percent) of STAR+PLUS enrollees needed treatment or counseling for a personal or family problem during the six months prior to the survey. Among those who needed treatment or counseling, 63 percent said it was usually or always easy to get treatment or counseling through their health plan.
- **Prescription medicines.** Eighty-one percent of STAR+PLUS enrollees received a new prescription or a prescription refill in the six months prior to the survey. Among those who got a new or refilled prescription, 82 percent said their medication was usually or always easy to get.
- **Care coordination.** Twenty-three percent of STAR+PLUS enrollees had a care coordinator, among whom 90 percent said they were "satisfied" or "very satisfied" with

their care coordinator. Overall, member experiences with care coordination were positive, with 64 percent of respondents indicating they usually or always received care coordination as soon as they thought it was needed, 69 percent reporting that their care coordinator usually or always explained things in a way they could understand, and 60 percent stating that their care coordinator usually or always involved them in decision-making. However, one-fifth (19 percent) of enrollees with care coordinators reported never being involved in decision-making.

- CAHPS composites. Descriptive results of CAHPS composite scores revealed that 86 percent of STAR+PLUS enrollees were satisfied with their Doctor's Communication compared to 75 percent with Getting Needed Care. Overall, composite scores were higher than in the prior fiscal year, with scores for Getting Needed Care, Getting Care Quickly, and Customer Service greater than in SFY2008. Multivariate analyses, which controlled for several individual factors, showed differences among health plans only for Getting Care Quickly, with scores for AMERIGROUP and Molina lower than scores for Superior.

APPENDIX A: CUSTOMER INVENTORIES BY AGENCIES (EXCEPT FOR DSHS)⁷⁶

**Texas Department Of Aging and Disability Services
DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET
STRATEGY**

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>A.1.1. Strategy: Intake, Access and Eligibility to Services and Supports. Provide functional eligibility determination, development of individual service plans based on customer needs and preferences, assistance in obtaining information, and authorization of appropriate services and supports through the effective and efficient management of DADS staff and contracts with the Area Agencies on Aging (AAAs) and local Mental Retardation Authorities (MRAs).</p>	<p>Direct customer groups include: Older individuals who meet specific eligibility requirements. Individuals with physical, intellectual and/or developmental disabilities who meet specific eligibility requirements. Family members and caregivers of the older individuals and persons with disabilities who meet specific eligibility criteria.</p>
<p>A.1.2. Strategy: Guardianship. Provide full or limited authority over an incapacitated elderly or disabled adult who is the victim of validated abuse, neglect exploitation in a non-institutional setting or of an incapacitated minor in CPS conservatorship, as directed by the court, including such responsibilities as managing estates, making medical decisions and arranging placement and care.</p>	<p>Direct customer groups include: Legally incompetent older adults who meet specific eligibility requirements. Legally incompetent adults with disabilities who meet specific eligibility requirements. Legally incompetent minors in CPS conservatorship.</p>

⁷⁶ The information Appendix A is from the current Health and Human Services System Strategic Plan for 2009-2013.

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>A.2.1. Strategy: Primary Home Care: Primary Home Care (PHC) is a Title XIX Medicaid-reimbursed, non-technical, non-skilled service, providing attendant services to individuals with an approved medical need for assistance with personal care tasks. PHC is available to eligible adults whose health problems cause them to be functionally limited in performing activities of daily living according to a practitioner’s statement of medical need.</p>	<p>Direct customer groups include: Individuals 21 years of age and older who meet eligibility requirements that include being Medicaid eligible, having a Practitioner’s statement of medical need and meeting functional assessment criteria.</p>
<p>A.2.2. Strategy: Community Attendant Services. Title XIX Medicaid-reimbursed program is a non-technical, non-skilled service, providing attendant services to individuals with an approved medical need for assistance with personal care tasks. CAS is available to eligible adults and children whose health problems cause them to be functionally limited in performing activities of daily living according to a practitioner’s statement of medical need.</p>	<p>Direct customer groups include: Individuals of any age who meet specific eligibility requirements including income and resources, who have a Practitioner’s statement of medical need and meet functional assessment criteria.</p>
<p>A.2.3. Strategy: Day Activity & Health Services. DAHS provide daytime service five days a week (Mon-Fri) to customers residing in the community in order to provide an alternative to placement in nursing facilities or other institutions.</p>	<p>Direct customer groups include: Title XIX: People of any age who receive Medicaid and meet eligibility requirements which include having a functional disability related to a medical condition, a need for a personal care task, and a medical diagnosis and physician’s orders requiring care or supervision by a licensed nurse. Title XX: Individuals age 18 or older who meet specific eligibility requirements including income and resources and who have a functional disability related to a medical condition, a need for a personal care task, and a medical diagnosis and physician’s orders requiring care or supervision by a licensed nurse.</p>
<p>1.3.1. Strategy: Community Based Alternatives (CBA). CBA program is a Title XIX Medicaid 1915(c) Home and Community-based services waiver and provides services to aged and disabled adults as a cost-effective alternative to institutionalization.</p>	<p>Direct customer groups include: Individuals 21 years of age or older who meet specific eligibility requirements including income, resource, and medical necessity requirements and who choose waiver services instead of nursing facility services.</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>A.3.2. Strategy: 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.</p>	<p>Direct customer groups include: Individuals of any age who have a determination/diagnosis of mental retardation or related condition, who meet specific income, resource and level of care criteria and who choose HCS services instead of the ICF/MR program.</p>
<p>A.3.3. Strategy: Community Living Assistance & Support Services (CLASS). Provides home and community-based services to persons who have a "related" condition diagnosis qualifying them for placement in an Intermediate Care Facility for persons who have a disability, other than mental retardation originating before age 22.</p>	<p>Direct customer groups include: Individuals of any age that have been diagnosed with a developmental disability other than mental retardation who meet specific eligibility requirements including income, resource, and functional need, and who choose waiver services instead of institutional services.</p>
<p>A.3.4. Strategy: Deaf-Blind Multiple Disabilities (DBMD). Provides home and community-based services to adult individuals diagnosed with deaf, blind, and multiple disabilities.</p>	<p>Direct customer groups include: Individuals of any age who are deaf, blind and have a third disability, who meet specific eligibility requirements including income, resources and functional need and who choose waiver services instead of institutional services</p>
<p>A.3.5. Strategy: Medically Dependent Children Program (MDCP). This 1915(c) waiver provides home and community-based services to customers less than 21 years of age. Services include respite, adjunct supports, adaptive aids, financial management services, minor home modifications and transition services.</p>	<p>Direct customer groups include: Individuals younger than age 21 who meet specific eligibility requirements including income, resource, and medical necessity criteria and who choose waiver services instead of nursing facility services.</p>
<p>A.3.6. Strategy: Consolidated Waiver Program: This pilot 1915c waiver consolidates CBA, MDCP, CLASS, HCS, and DBMD waivers. Community Services and Supports case managers develop individualized service plans based on the participant's needs.</p>	<p>Direct customer groups include: Individuals of any age who meet specific eligibility requirements including income, resource and functional need, who choose waiver services instead of institutional services, and who are on the interest list in Bexar county for CBA, CLASS, DBMD HCS or MDCP waiver services.</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>A.3.7. Strategy: 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 \$15,000 per year to consumers living in their family's home or their own homes.</p>	<p>Direct customer groups include: Individuals of any age who have a determination/diagnosis of mental retardation or related condition, who meet specific eligibility requirements including income, resource and level of care criteria, and who choose waiver services over ICF/MR.</p>
<p>A.4.1. Strategy: Non-Medicaid Services. Provide a wide range of home and community-based social and supportive services to elderly and disabled persons who are not eligible for Medicaid that will assist these individuals to live independently, including family care, adult foster care, day activity and health services (Title 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.</p>	<p>Direct customer groups include: For the Non-Medicaid community (Title XX and General Revenue funded) services Individuals who are 18 years of age or older who meet specific eligibility requirements including income, resource, and functional assessment criteria.</p> <p>For the OAA services: Individuals who are 60 years of age or older. Individuals who have cognitive and/or physically disabilities Family members and caregivers of older adults and individuals with disabilities.</p>
<p>A.4.2. Strategy: Mental Retardation Community Services. Provide services, other than those provided through the Medicaid waiver programs, to persons with mental retardation who reside in the community including independent living, employment services, day training, therapies, and respite.</p>	<p>Direct customer groups include: Individuals who have a determination/diagnosis of mental retardation who reside in the community.</p>
<p>A.4.3. Strategy: 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.</p>	<p>Direct customer groups include: Individuals who are covered by Medicaid and living in an institution but wish to relocate from an institution back into the community.</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>A.4.4. Strategy: In-Home and Family Support. Provide cash subsidy and provide reimbursement for capital improvements, purchase of equipment, and other expenses to enable persons with physical disabilities to maintain their independence and prevent institutionalization.</p>	<p>Direct customer groups include: Individuals with physical disabilities who need to purchase items that are above and beyond the scope of usual needs that are necessitated by the person's disability and that directly support that person to live in his/her natural home.</p>
<p>A.4.5. Strategy: MR In-Home Services. The mental retardation portion of the In-Home and Family Support (IHFS) program. Provides financial assistance to adults or children with a mental disability or to their family for the purpose of purchasing items that are above and beyond the scope of usual needs, that are necessitated by the person's disability and that directly support that person to live in his/her natural home.</p>	<p>Direct customer groups include: Adults or children with a mental/cognitive disability who need to purchase items that are above and beyond the scope of usual needs, that are necessitated by the person's disability and that directly support that person to live in his/her natural home.</p>
<p>A.5.1. Strategy: Program of All-Inclusive Care for the Elderly (PACE). The PACE program provides community-based services to frail and elderly people who qualify for nursing facility placement. Services may include in-patient and outpatient medical care at a capitated rate.</p>	<p>Direct customer groups include: Individuals age 55 or older who are frail, who qualify for nursing facility services, and receive Medicare and/or Medicaid.</p>
<p>A.6.1. Strategy: Nursing Facility 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.</p>	<p>Direct customer groups include: Individuals with medical needs meeting medical necessity requirements and are eligible for Medicaid. The individuals must reside in a nursing facility for 30 consecutive days.</p>
<p>A.6.2. Strategy: Medicare Skilled Nursing Facility. Provide co-insure payments for Medicaid recipients residing in Medicare (XVIII) skilled nursing facilities, for Medicaid/Qualified Medicare Beneficiary (QMB) recipients and for Medicare only QMB recipients.</p>	<p>Direct customer groups include: Individuals who receive Medicaid and reside in Medicare (XVIII) skilled nursing facilities, Medicaid/Qualified Medicare Beneficiary (QMB) recipients and Medicare only QMB recipients.</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>A.6.3. Strategy: 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 customers for whom curative treatment is no longer desired and who have a physician's prognosis of six months or less to live.</p>	<p>Direct customer groups include: Individuals eligible for Medicaid who are terminally ill for whom curative treatment is no longer desired and who have a physician's prognosis of six months or less to live.</p>
<p>A.6.4. Strategy: Promoting Independence Services. Provide community-based services that enable nursing facility customers to relocate from nursing facilities back into community settings.</p>	<p>Direct customer groups include: Individuals eligible for Medicaid residing in a nursing facility who are relocating into community settings.</p>
<p>A.7.1. Strategy: Intermediate Care Facilities - Mental Retardation (ICF/MR): The Intermediate Care Facilities for Mental Retardation (ICF/MR) are residential facilities of four or more beds providing 24-hour care. Funding for ICF/MR services is authorized through Title XIX of the Social Security Act (Medicaid).</p>	<p>Direct customer groups include: Individuals with intellectual and/or developmental disabilities who would benefit or require 24-hour supervised living arrangements and qualify for Medicaid.</p>
<p>A.8.1. Strategy: MR State Supported Living Centers. Provides direct services and support to persons living in state centers. State Centers provide 24-hour residential services for persons with mental retardation who are medically fragile or severely physically impaired or have severe behavior problems and who choose these services or cannot currently be served in the community.</p>	<p>Direct customer groups include: Individuals who have a determination/diagnosis of mental retardation who are medically fragile or have severe physical impairments or severe behavioral problems, have chosen to live in a state center, or cannot currently be served in the community.</p>

Department of Assistive and Rehabilitative Services

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>A.1.1. Strategy: Comprehensive 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.</p>	<p>Children with Disabilities & Their Families: DARS is responsible for determining the eligibility of all children under age three with developmental disabilities or delays, and for providing early intervention services to all eligible children and their families.</p>
<p>A.1.2. Strategy: 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.</p>	<p>Children with Disabilities & Their Families: DARS provides respite services to families served by the ECI program.</p>
<p>A.1.3. Strategy: Ensure Quality 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.</p>	<p>Children with Disabilities & Their Families: DARS carries out activities required under the Individuals with Disabilities Education Act (IDEA), including ensuring the availability of qualified personnel to serve all eligible children, involving families and stakeholders in policy development, evaluating services, providing impartial opportunities for resolution of disputes, and guaranteeing the rights of the children and families are protected.</p>
<p>A.2.1. Strategy: 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.</p>	<p>Blind or Visually Impaired Consumers & Their Families: DARS provides services necessary to assist blind children to achieve self-sufficiency and a fuller richer life.</p>
<p>B.1.1. Strategy: 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.</p>	<p>Blind or Visually Impaired Consumers: DARS is responsible for providing services that assist Texans with visual disabilities to live as independently as possible.</p>
<p>B.1.2. Strategy: Blindness Education. Provide screening, education, and urgently needed eye-medical treatment to prevent blindness.</p>	<p>Citizens of Texas: DARS provides public education about blindness, screenings and eye exams to identify conditions that may cause blindness and treatment procedures necessary to prevent blindness.</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>B.1.3. Strategy: 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.</p>	<p>Blind or Visually Impaired Consumers: DARS provides services designed to assess, plan, develop and use vocational rehabilitation services for individuals who are blind consistent with their strengths, resources, priorities, concerns and abilities so that they may prepare for and engage in gainful employment.</p> <p>Citizens of Texans/Taxpayers: The VR program: DARS promotes employment, reducing dependence on state-funded programs and increasing tax revenue for the state.</p> <p>Employers: DARS work with people with disabilities and employers to identify appropriate job placements for these individuals.</p>
<p>B.1.4. Strategy: Business Enterprises of Texas. Provide employment opportunities in the food service industry for persons who are blind or visually impaired.</p>	<p>Blind or Visually Impaired Consumers: DARS provides training and employment opportunities in the food service industry for Texans who are blind or visually impaired.</p>
<p>B.1.5. Strategy: 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).</p>	<p>Blind or Visually Impaired Consumers: DARS has established and maintains a retirement and benefit plan for blind or visually impaired individuals who are licensed managers in the Business Enterprise of Texas program.</p>
<p>B.2.1. Strategy: Contract Services. Develop and implement a statewide program to ensure continuity of services to persons who are deaf or hard of hearing. Ensure more effective coordination and cooperation among public and nonprofit organizations providing social and educational services to individuals who are deaf or hard of hearing.</p>	<p>Deaf or Hard of Hearing Consumers: DARS, through a network of local service providers at strategic locations throughout the state, provides communication access services including interpreter services and computer assisted real-time transcription services, information and referral, hard of hearing services, and resource specialists' services.</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>B.2.2. Strategy: Consumer and Interpreter Education. 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.</p> <p>Interpreters Certification. To test interpreters for the deaf and hard of hearing to determine skill level and certify accordingly, and to regulate interpreters to ensure adherence to interpreter ethics.</p>	<p>Deaf or Hard of Hearing Consumers; DARS provides services through a statewide program of advocacy and education on topics such as ADA, hard of hearing issues and interpreter training.</p> <p>Higher Education Institutions and Students: DARS assists institutions of higher education in initiating training programs for interpreters.</p> <p>Current and Potential Interpreters: DARS provides skills building and training opportunities for interpreters and coordinates training sponsored by other entities.</p> <p>Current and Potential Interpreters: DARS administers a system to determine the varying levels of proficiency of interpreters and maintains a certification program for interpreters.</p> <p>Deaf or Hard of Hearing Consumers: DARS ensures that interpreters are able to adequately assist in the communication facilitation process for people who are deaf or hard of hearing.</p>
<p>B.2.3. Strategy: Telephone Access Assistance. Ensure equal access to the telephone system for persons with a disability.</p>	<p>Consumers with Disabilities: DARS provides vouchers for the purchase of specialized telecommunications equipment for access to the telephone network for eligible persons with disabilities..</p>
<p>B.3.1. Strategy: Vocational Rehabilitation - General. Rehabilitate and place people with general disabilities in competitive employment or other appropriate settings, consistent with informed consumer choice and abilities.</p>	<p>Vocational Rehabilitation Consumers: DARS provides services leading to employment consistent with consumer choice and abilities for eligible persons with disabilities.</p> <p>Citizens of Texans/Taxpayers: The VR program promotes employment, reducing dependence on state-funded programs and increasing tax revenue for the state.</p> <p>Employers: DARS works with people with disabilities and employers to identify appropriate job placements for these individuals.</p>
<p>B.3.2. Strategy: 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 providing core services to their customers.</p>	<p>Consumers with Disabilities: Centers for Independent Living offer services to eligible consumers with significant disabilities who are interested and can benefit, regardless of vocational potential. Centers provide, at the minimum, the following core services: advocacy, peer counseling, independent living skills training, and information and referral.</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>B.3.3. Strategy: Independent Living Services - General. Provide consumer-driven and DARS counselor-supported independent living services to people with significant disabilities.</p>	<p>Consumers with Disabilities: DARS provides people with significant disabilities, who are not receiving vocational rehabilitation services, with services that will substantially improve their ability to function, continue functioning, or move toward functioning independently in the home, family, or community.</p>
<p>B.3.4. Strategy: Comprehensive Rehabilitation. Provide consumer-driven and counselor-supported Comprehensive Rehabilitation Services for people with traumatic brain injuries or spinal cord injuries.</p>	<p>Consumers with Traumatic Brain or Spinal Cord Injuries: DARS provides adults who have suffered a traumatic brain or spinal cord injury with comprehensive inpatient or outpatient rehabilitation and/or acute brain injury services if other resources are not available.</p>
<p>C.1.1. Strategy: Disability Determination Services (DDS). Determine eligibility for federal Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits.</p>	<p>Texas Citizens Applying for SSI or SSDI: DARS determines whether persons who apply for Social Security Administration (SSA) disability benefits meet the requirements for “disability” in accordance with federal law and regulations.</p> <p>Federal government: DARS assists SSA in making disability determination decisions for this federal program in a quick, accurate and cost-effective manner.</p>
<p>D.1.1. Strategy: Central Program Support.</p>	<p>DARS Employees: DARS provides central support services for DARS employees.</p>
<p>D.1.2. Strategy: Regional Program Support.</p>	<p>DARS Employees: DARS provides central support services for DARS employees.</p>
<p>D.1.3. Strategy: Other Program Support.</p>	<p>DARS Employees: DARS provides central support services for DARS employees.</p>
<p>D.1.4. Strategy: IT Program Support Information. Technology Program Support.</p>	<p>DARS Employees: DARS provides central support services for DARS employees.</p>

Department of Family and Protective Services

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>Strategy A.1.1 Statewide Intake 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, emails, or the Internet.</p>	<p>Children and Adults At Risk of Abuse and Neglect: Statewide Intake provides central reporting and investigation assignments so that all children at risk of abuse and neglect and all elderly and adults with disabilities at risk of abuse, neglect, and exploitation can be protected.</p> <p>Citizens of Texas: DFPS provides confidential access to services for all citizens of Texas.</p> <p>External Partners: In providing access to DFPS services through the Statewide Intake function, DFPS interacts with law enforcement agencies, the medical sector, schools, and the general reporting public.</p>
<p>Strategy A.2.1 CPS Direct Delivery Staff. Provide caseworkers and related staff to conduct investigations and deliver family preservation/reunification services, out of home care, and permanency planning for children who are at risk of abuse/neglect and their families.</p> <p>Strategy A.2.2 CPS Program Support. Provide staff, training, automation, and special projects to support a comprehensive and consistent system for the delivery of child protective services.</p>	<p>Children and Families: DFPS protects children by investigating reports of abuse and neglect, working with children and families in their own homes to alleviate the effects of abuse/neglect and providing services to prevent further abuse/neglect, and if necessary, placing children in substitute care until they can be safely returned home, to relatives, or until they are adopted.</p> <p>External Partners: Conducting investigations and providing casework for children in their own homes and children who have been removed from their homes involves many external partners, such as law enforcement agencies, the medical sector, schools, Child Welfare Boards, the judiciary, faith based organizations, Child Advocacy Centers, children’s advocate groups, domestic violence service providers, other HHSC enterprise agencies, and state and national child welfare associations.</p>
<p>Strategy A.2.3 TWC Foster Day Care. Provide purchased day care services for foster children when one or both foster parents work full-time.</p> <p>Strategy A.2.4 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.</p>	<p>Children and Families: DFPS protects children by purchasing day care to keep a child safe in their home or to assist working foster parents.</p> <p>Other Agencies: DFPS purchases day care under a contract with the Texas Workforce Commission.</p> <p>Local Governments: Through the contract with the Texas Workforce Commission, DFPS has access to the network of child care providers managed by local workforce boards.</p>
<p>Strategy A.2.5 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,</p>	<p>Children and Families: DFPS increases permanency placement options for children awaiting adoption by contracting for adoption services, and helps ensure success of adoptions by providing post-adoption services.</p> <p>Contracted Service Providers: DFPS contracts with private child-placing agencies to recruit, train and verify adoptive homes, handle adoptive placements, provide post-placement supervision, and</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>screening, home study, placement, and support services.</p> <p>Strategy A.2.6 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.</p>	<p>facilitate the consummation of the adoptions. DFPS also purchases post-adoption services from various service providers.</p>
<p>Strategy A.2.7 Preparation for Adult Living Purchased Services. Provide purchased preparation for adult living services to help and support youth preparing for departure from DFPS substitute care, including life skills training, money management, vocational support, room and board assistance, and case management.</p>	<p>Youth in Substitute Care: DFPS provides services to prepare youth in substitute care for adult life. Services are also available for youth who have aged out of the substitute care system to ensure a successful transition to adulthood.</p> <p>Contracted Service Providers: DFPS purchases these youth services from various service providers.</p>
<p>Strategy A.2.8 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.</p>	<p>Children and Families: DFPS protects children by purchasing substance abuse treatment services and drug-testing services for children in the CPS system and their families.</p> <p>Contracted Service Providers: DFPS purchases these services from various service providers.</p>
<p>Strategy A.2.9 Other CPS Purchased Services. Provide purchased services to treat children who have been abuse 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.</p>	<p>Children and Families: DFPS protects children by purchasing various types of services for children in the CPS system and their families. Services include evaluation of psychological and psychiatric functioning; individual, group, and family therapy, parenting, battering intervention, life skills, etc.</p> <p>Contracted Service Providers: DFPS purchases these services from various service providers.</p>
<p>Strategy A.2.10 Foster Care Payments. Provide financial reimbursement for the care, maintenance, and support of children who have been removed from their</p>	<p>Children in Foster Care: DFPS provides reimbursement for the care, maintenance, and treatment of children who have removed from their homes.</p> <p>Kinship and Other Designated Caregivers: DFPS provides monetary assistance to kinship and other designated caregivers to help</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
homes and placed in licensed, verified child care facilities.	<p>ensure successful placements for children removed from their homes.</p> <p>Contracted Service Providers: DFPS purchases these services from DFPS foster homes, contracted child-placing agencies, and child care facilities.</p> <p>Other Agencies: DFPS provides federal Title IV-E funding for eligible children in the custody of the Texas Youth Commission and the Texas Juvenile Probation Commission, as well as their administrative costs for reasonable candidates for foster care.</p> <p>Local Governments: DFPS provides federal Title IV-E funding to participating counties for allowable expenses for foster care maintenance and administration.</p> <p>External Partners: The foster care program would not be possible without the 24-hour residential child care providers. DFPS works closely with provider groups and associations.</p>
<p>Strategy A.2.11 Adoption Subsidy Payments. Provide grant benefit payments for families that adopt foster children with special needs who could not be placed in adoption without financial assistance.</p>	<p>Children and Families: DFPS helps ensure a permanent placement for children available for adoption with special needs by providing a monthly subsidy payment to assist with the cost of the child’s special needs.</p>
<p>Strategy A.2.12 Services to At-Risk Youth (STAR) Program. Provide contracted prevention services for youth ages 10-17 who are in at-risk situations, runaways, or Class C delinquents, and for youth younger than age of 10 who have committed delinquent acts.</p> <p>Strategy A.2.13 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.</p> <p>Strategy A.2.14 Texas Families Program. Provide community-based prevention services to alleviate stress and promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children.</p> <p>Strategy A.2.15 Child Abuse Prevention Grants. Provide child abuse prevention grants to develop programs, public awareness, and</p>	<p>Children and Families: DFPS provides funding for community-based child abuse prevention and juvenile delinquency prevention services to at-risk children and for the families of those children.</p> <p>Contracted Service Providers: DFPS contracts with various community-based organizations across the state to deliver all the prevention and early intervention services described in A.2.12 through A.2.17.</p> <p>Other Agencies: At-risk prevention services involve participation from the Texas Education Agency, Texas Juvenile Probation Commission, and Texas Youth Commission.</p> <p>Local Governments: At-risk prevention services involve participation from Local Juvenile Probation Departments. Some prevention services are provided through contracts with local governments.</p> <p>External Partners: Overseeing prevention services involves many external partners such as law enforcement agencies, schools, and children’s advocate groups.</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
<p>respite care through community-based organizations.</p> <p>Strategy A.2.16 Other At-Risk Prevention Programs. Provide funding for community-based prevention programs to alleviate conditions that lead to child abuse/neglect and juvenile crime.</p> <p>Strategy A.2.17 At-Risk Prevention Program Support. Provide program support for at-risk prevention services.</p>	
<p>Strategy A.3.1 APS Direct Delivery Staff. Provide caseworkers and related staff to conduct investigations and provide or arrange for services for vulnerable adults.</p> <p>Strategy A.3.2 APS Program Support. Provide staff, training, automation, and special projects to support a comprehensive and consistent system for the delivery of adult protective services.</p>	<p>Aged and Disabled Victims: DFPS protects elderly persons and adults with disabilities by investigating reports of abuse, neglect, and exploitation, and providing services to remedy or prevent further abuse.</p> <p>Contracted Service Providers: DFPS contracts with various service providers to deliver necessary emergency services for APS customers.</p> <p>Other Agencies: Adult protective services include support and involvement from the Texas Department of Aging and Disability Services (DADS) and the Texas Department of Assistive and Rehabilitative Services (DARS).</p> <p>Local Governments: Providing adult protective services involves support and participation from city and county health and social services departments, and the Area Agencies on Aging.</p> <p>External Partners: Conducting investigations and providing services involves many external partners, such as law enforcement agencies, the medical sector, the judiciary, faith based organizations, advocate groups for elderly persons and adults with disabilities, state and national associations on aging and care for the elderly, and family and friends of APS customers.</p>
<p>Strategy A.3.3 MH and MR Investigations. Provide a comprehensive and consistent system for the investigation of reports of abuse, neglect, and exploitation of persons receiving services in mental health and mental retardation settings.</p>	<p>Persons Served by or through MH and MR Settings: DFPS protects persons served by or through MH and MR settings by investigating reports of abuse, neglect, and exploitation.</p> <p>Other Agencies: Adult protective services for persons served in these settings include support and involvement from the Texas Department of Aging and Disability Services (DADS), the Texas Department of State Health Services (DSHS), and the Texas Department of Assistive and Rehabilitative Services (DARS).</p> <p>Local Governments: Providing adult protective services for persons</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
	<p>served in these settings involves support and participation from Community MHMR Centers.</p> <p>External Partners: Providing adult protective services for persons served in these settings involves many external partners, such as advocate groups for persons with mental illness and mental retardation, state and national associations for mental health, and family and friends of MH and MR patients.</p>
<p>Strategy A.4.1 Child Care Regulation. Provide a comprehensive system of consultations, licensure, and regulation to ensure maintenance of minimum standards by day care and residential child care facilities, registered family homes, child-placing agencies, and facility administrators.</p>	<p>Children and Families: DFPS helps ensure the safety and well-being of children in day care and 24-hour care settings by enforcement of minimum standards and investigating reports of abuse and neglect in child care facilities.</p> <p>Other State Agencies: Child care regulation involves support and participation by Texas Workforce Commission, Texas Department of State Health Services (DSHS), and other regulatory agencies.</p> <p>Local Governments: DFPS regulation of child care facilities involves the network of child care providers managed by local workforce boards. It also includes local health agencies and fire inspectors.</p> <p>External Partners: DFPS regulation of child care facilities includes listed family homes, registered family homes, maternity homes, licensed residential child care facilities, and licensed day care facilities. Other external partners in ensuring safety of children in childcare settings include schools, child care administrators, children’s advocates, and parents.</p>
<p>Strategy B.1.1. Central Administration.</p> <p>Strategy B.1.2 Other Support Services.</p> <p>Strategy B.1.3 Regional Administration.</p> <p>Strategy B.1.4 IT Program Support.</p> <p>Strategy B.1.5 Agency-wide Automated System. Develop and enhance automated systems that service multiple programs, including the Information Management Protecting Adults and Children of Texas (IMPACT) system.</p>	<p>DFPS provides indirect administrative support for all programs. All stakeholder groups would be included for this group of strategies. Additionally, DFPS employees receive support services under these strategies.</p>
<p>Strategy C.1.1 CPS Reform.</p>	<p>Children and Families: DFPS protects children by investigating reports of abuse and neglect, working with children and families in their own homes to alleviate the effects of abuse/neglect and providing services to prevent further abuse/neglect, and if necessary, placing children in substitute care until they can be safely returned home, to relatives, or until they are adopted.</p>

STRATEGY	STAKEHOLDER GROUPS/SERVICES PROVIDED
	<p>External Partners: Conducting investigations and providing casework for children in their own homes involves many external partners, such as law enforcement agencies, the medical sector, schools, Child Welfare Boards, the judiciary, faith based organizations, Child Advocacy Centers, children’s advocate groups, domestic violence service providers, other HHSC enterprise agencies, and state and national child welfare associations.</p> <p>Contracted Service Providers: DFPS purchases necessary services for children in the CPS system and their families from various service providers.</p>

Health and Human Services Commission

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy A.1.1 Enterprise Oversight and Policy. Provide leadership and direction to achieve an efficient and effective health and human services system.</p>	<p>Oversight agencies and Legislative Leadership: HHSC coordinates and monitors the use of state and federal money received by HHS agencies; reviews state plans submitted to the federal government; monitors state health and human services agency budgets and programs, and makes recommendations for budget transfers; conducts research and analyses on demographics and caseload projections; and directs an integrated planning and budgeting process across five 12 HHS agencies.</p> <p>Other 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 efficient.</p> <p>Citizens of Texas: HHSC ensures that state and federal funds allocated to HHS agencies are coordinated and monitored, and spent in the most efficient manner.</p> <p>Local Governments: HHSC provides assistance to local governments in obtaining federal funds.</p> <p>Children & Families: HHSC oversees interagency Community Resource Coordination Groups (CRCGs) for Texas children and adolescents with complex needs; and provides a forum to improve the service delivery system for children and youth through overarching planning, coordination, and integration across education, juvenile justice, and health and human services agencies.</p>
<p>Strategy A.1.2. Integrated Eligibility and Enrollment Provide accurate and timely eligibility and issuance services for financial assistance, medical benefits, and food stamps.</p>	<p>Children & Families: The functions involved in both centralizing and conducting eligibility determination for HHS programs will apply to children and families seeking to participate in the Medicaid, TANF, Food Stamp and other health and human services programs.</p>
<p>Strategy A.2.1. Consolidated System Support. Improve the operations of health and human service agencies through coordinated efficiencies in business support functions.</p>	<p>Other HHS Agencies. HHSC provides the leadership for consolidating across the enterprise the functions of: information technology, human resources, civil rights, procurement, ombudsman and other services, e.g. facility management and leasing and regional operations.</p>
<p>Strategy B.1.1. Medicare and SSI. Provide medically necessary health care in the most appropriate accessible and cost effective setting to Medicaid-aged and Medicare-related persons and Medicaid disabled and blind persons.</p>	<p>Medicaid Consumers: HHSC Medicaid/CHIP division provides health care to Medicaid aged and Medicare related persons and persons who are disabled or blind.</p>
<p>Strategy B.1.2. TANF Adults and Children. Provide medically necessary health care in the most</p>	<p>Medicaid Consumers: HHSC Medicaid/CHIP division provides health care to adults and children who are eligible for TANF.</p>

STRATEGY	STAKEHOLDER GROUPS/ SERVICES PROVIDED
appropriate, accessible, and cost effective setting to Temporary Assistance for Needy Families (TANF) eligible adults and children.	
Strategy B.1.3. Pregnant Women. Provide medically necessary health care in the most appropriate, accessible, and cost effective setting to Medicaid-eligible pregnant women.	Medicaid Consumers: HHSC Medicaid/CHIP division provides health care to women who are pregnant and eligible for Medicaid.
Strategy B.1.4. Children and Medically Needy. Provide medically necessary health care in the most appropriate, accessible, and cost effective setting to newborn infants and Medicaid-eligible children above the TANF income eligibility criteria, and to medically needy persons.	Medicaid Consumers: HHSC Medicaid/CHIP division provides health care to infants and children who are above the TANF eligibility criteria and medically needy persons.
Strategy B.1.5. Medicare Payments. Provide accessible premium-based health services to certain Title XVIII Medicare-eligible recipients.	Medicaid Consumers: HHSC Medicaid/CHIP division provides premium-based health services to certain Title XVIII Medicare eligible recipients.
Strategy B.1.6. STAR+PLUS (Integrated Managed Care). Promote the development of integrated managed care systems for aged and disabled customers.	Medicaid Managed-care Consumers. HHSC Medicaid/CHIP division provides acute and long-term health care to consumers who are disabled and blind and older persons who need long-term care services through Medicare.
Strategy B.2.1. Cost Reimbursed Services: Provide medically necessary health care to Medicaid eligible recipients for services not covered under the insured arrangement including: federally qualified health centers, undocumented persons, school health, and related services.	Medicaid Consumers: HHSC Medicaid/CHIP division provides health care to Medicaid eligible recipients for specific services not covered.
Strategy B.2.2. Medicaid Vendor Drug Program. Provide prescription medication to Medicaid-eligible recipients as prescribed by their treating physician.	Medicaid Consumers: HHSC Medicaid/CHIP division provides prescription medication benefits to Medicaid recipients.
Strategy B.2.3. Medical Transportation. Support and reimburse for non-emergency transportation assistance to individuals receiving medical	Medicaid Consumers: HHSC provides transportation for Medicaid recipients.

STRATEGY	STAKEHOLDER GROUPS/ SERVICES PROVIDED
assistance.	
Strategy B.2.4. Medicaid Family Planning. Increase family planning services throughout Texas for adolescents and women,	Medicaid Consumers: HHSC Medicaid/CHIP division provides family planning services for Medicaid recipients.
Strategy B.2.5. Upper Payment Limit. Provide supplemental Medicaid reimbursement to children hospitals for inpatient and outpatient services.	Hospitals/Providers: States may receive federal funding to provide hospitals supplemental payments to cover inpatient and outpatient services that exceed regular Medicaid rates.
Strategy B.3.1. Health Steps (EPSDT) Medical. Provide access to comprehensive diagnostic/treatment services for eligible customers by maximizing the use of primary prevention, early detection and management of health care in accordance with all federal mandates.	Medicaid Consumers: HHSC Medicaid/CHIP division provides diagnostic/treatment services to Medicaid-eligible children.
Strategy B.3.2. Health Steps (EPSDT) Dental. Provide dental care in accordance with all federal mandates.	Medicaid Consumers: HHSC Medicaid/CHIP division provides dental services to Medicaid-eligible children.
Strategy B.3.3. EPSDT Comprehensive Care Program. Provide all medically necessary and federally allowable Medicaid services for conditions identified through an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screen or other health care encounter but not covered or provided under the State Medicaid Plan.	Medicaid Consumers: HHSC Medicaid/CHIP division provides diagnostic/treatment services to Medicaid-eligible children.
Strategy B.4.1. State Medicaid Office. Set the overall policy direction of the state Medicaid program and manage interagency initiatives to maximize federal dollars.	Other HHS Agencies. HHSC provides the leadership and policy planning for administration of the state Medicaid Office across the HHS enterprise.
Strategy C.1.1. CHIP. Provide health care to uninsured children who apply for insurance through CHIP. Strategy C.1.2. Immigrant Children Health Insurance. Provide health care to certain uninsured, legal, immigrant children	Federal Government: HHSC Medicaid/CHIP division provides direction, guidance, and policy making for the Children’s Health Insurance Program, a federal program administered through states. Managed Care Organizations: The HHSC Medicaid/CHIP division contracts with Managed Care Organizations for the provision of the Children’s Health Insurance Program. The Medicaid/CHIP division sets policy and provides oversight for the CHIP program.

STRATEGY	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>who apply for insurance through CHIP.</p> <p>Strategy C.1.3. School Employee Children Insurance. Provide health care to children of certain school employees who apply for insurance through CHIP. .</p> <p>Strategy C.1.4. CHIP Perinatal Services Provide health care to perinates whose mothers apply for insurance through CHIP.</p> <p>Strategy C.1.5. CHIP Vendor Drug Program. Provide prescription medication to CHIP-eligible recipients (includes Immigrant Health Insurance and School Employee Children Insurance), as provided by their treating physician.</p>	<p>Children and Families: The CHIP program exists to serve Texas children and families, providing health insurance to children in families with incomes up to 200% of the federal poverty level.</p>
<p>Strategy D.1.1. TANF (Cash Assistance) Grants. Provide TANF grants to low-income Texans.</p>	<p>Children and Families. The TANF grants provide capped entitlement services, non-entitlement services, one-time payments, child support payments and payment support for grandparents to children and families.</p>
<p>Strategy D.1.2. Refugee Assistance. Assist refugees in attaining self-sufficiency through financial, medical, and social services, and disseminate information to interested individuals.</p>	<p>Children and Families. HHSC’s division of Family Services provides refugee assistance to immigrants coming into Texas.</p>
<p>Strategy D.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.</p>	<p>Children and Families. HHSC’s division of Family Services provides family violence services to children and families.</p>
<p>Strategy D.2.2. Alternatives to Abortion. Provide pregnancy support services that promote childbirth for women seeking alternatives to abortion.</p>	<p>Pregnant Women and Children: Provide support services such as referrals, counseling, support groups, and material goods during pregnancy and first year of child’s life.</p>
<p>Strategy E.1.1. Central Program Support.</p>	<p>HHS Employees. HHSC provides central support services for HHS employees.</p>
<p>Strategy E.1.2. IT Program Support.</p>	<p>HHS Employees. HHSC provides central support services for HHS employees.</p>
<p>Strategy E.1.3. Regional Program Support.</p>	<p>Other HHS Agencies: HHSC provides the leadership to assist the HHS agencies in developing in providing to support to regional programs.</p>

STRATEGY	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	<p>Citizens of Texas: HHSC ensures that state and federal funds allocated to HHS agencies are coordinated and monitored, and spent in the most efficient manner.</p>
<p>Strategy F.1.1. TIERS and Eligibility Technologies.</p>	<p>Other HHS Agencies: HHSC provides the leadership to assist the HHS agencies in developing the TIERS system.</p> <p>Children & Families: HHSC ensures the accessibility of TIERS to children and families across Texas.</p>
<p>Strategy G.1.1. Office of Inspector General (OIG). 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 customers and providers.</p>	<p>Citizens of Texas/Taxpayers: OIG serves as the lead agency for the investigation of fraud, abuse and waste in health and human services; and administers the Medicaid Fraud and Abuse Detection System technology services contract, which uses technology to identify and deter fraud, abuse and waste in the Medicaid program throughout the state.</p> <p>Medicaid Providers: OIG provides training to Medicaid providers on how to detect, prevent and report Medicaid provider fraud; and provides training on Texas Index level of Effort (TILE) for nursing facilities.</p> <p>Medicaid Consumers: OIG investigates fraud, abuse and waste in health and human services-related programs, ensuring integrity and efficiency in programs and the highest quality services for beneficiaries.</p> <p>Residents of Facilities: OIG monitors Utilization Review activities in Medicaid contract hospitals to ensure program integrity and improve the quality of services delivered to residents of Medicaid facilities.</p>

APPENDIX B: HHS ENTERPRISE CUSTOMER SATISFACTION SURVEY INSTRUMENTS AND SAMPLE CORRESPONDENCE

English Versions (Reduced to fit page)

Survey of Youth Under Age 18⁷⁷

First I have some questions about the services [Fname] has received from [INSERT PROGRAM AND AGENCY NAME FROM WHICH THE CHILD WAS SAMPLED: (1) the Medically Dependent Children Program (MDCP) under the Texas Department of Aging & Disability Services (DADS), (2) the Early Childhood Intervention Services Program (ECI) under the Texas Department of Assistive and Rehabilitative Services (DARS), (3) Substitute Care under the Texas Department of Family and Protective Services (DFPS), (4) the Children with Special Health Care Needs Services Program (CHSCN) under the Texas Department of State Health Services (DSHS), or (5) Personal Care Services (PCS) under the Texas Health and Human Services Commission (HHSC)].

Please answer with the response that best describes your opinion.

HHS_1 It wasn't difficult for [Fname] to get the benefits or services [he/she] needed from [INSERT PROGRAM AND AGENCY NAME].

- (1) Agree
- (2) Somewhat Agree
- (3) Somewhat Disagree
- (4) Disagree
- (77) DON'T KNOW
- (99) REFUSED

HHS_2 The length of time [Fname] waited to receive [INSERT PROGRAM AND AGENCY NAME] benefits or services was reasonable.

- (1) Agree
- (2) Somewhat Agree
- (3) Somewhat Disagree
- (4) Disagree
- (77) DON'T KNOW
- (99) REFUSED

HHS_3 Overall, I am satisfied with the benefits or services [Fname] received from [INSERT PROGRAM AND AGENCY NAME].

- (1) Agree
- (2) Somewhat Agree
- (3) Somewhat Disagree
- (4) Disagree
- (77) DON'T KNOW
- (99) REFUSED

⁷⁷ These agency-specific questions are part of a larger survey about how well available services meet the needs of CHSCN. The larger survey is an adapted version of two surveys used nationally: the National Survey of Children with Special Health Care Needs and the PedsQL. The survey was conducted by the University of North Texas Survey Research Center. It is anticipated that the report will be available late in the summer of 2010.

Survey of Youth Ages 18-21

First I have some questions about the services [you have/Fname has] received from [INSERT PROGRAM AND AGENCY NAME FROM WHICH THE CHILD WAS SAMPLED: (1) the Medically Dependent Children Program (MDCP) under the Texas Department of Aging & Disability Services (DADS), (2) Substitute Care under the Texas Department of Family and Protective Services (DFPS), (3) the Children with Special Health Care Needs Services Program (CSHCN) under the Texas Department of State Health Services (DSHS), or (4) Personal Care Services (PCS) under the Texas Health and Human Services Commission (HHSC)]

Please answer with the response that best describes your opinion.

HHS_1 It was easy for [me/Fname] to get the benefits or services [I/Fname] needed in the [INSERT PROGRAM AND AGENCY NAME].

- (1) Agree
- (2) Somewhat Agree
- (3) Somewhat Disagree
- (4) Disagree
- (5) Don't know
- (99) REFUSED

HHS_2 The length of time [I/Fname] waited to receive benefits or services from [INSERT PROGRAM AND AGENCY NAME] was reasonable.

- (5) Agree
- (6) Somewhat Agree
- (7) Somewhat Disagree
- (8) Disagree
- (9) Don't know
- (99) REFUSED

HHS_3 Overall, [I am/Fname is] satisfied with the benefits or services [I/he/she] received from [INSERT PROGRAM AND AGENCY NAME].

- (5) Agree
- (6) Somewhat Agree
- (7) Somewhat Disagree
- (8) Disagree
- (9) Don't know
- (99) REFUSED

Pre-notification Letters for Parents of Youth Under Age 18 with Telephone Number on Record



SURVEY RESEARCH CENTER

<<DATE>>

<<MERGE FIELDS>>

Dear Parent or Guardian:

We need your help. The University of North Texas Survey Research Center is conducting an important survey about the health care needs of children, and teenagers, and the health services they use. We're especially interested in your experiences with health care providers and with «Agency_name».

This survey is very important because it will help policy makers decide how to improve health services for young people with experiences similar to yours. This is your chance to help this agency serve you better.

This survey is funded by the Texas Health and Human Services Commission (HHSC). It is being conducted by the Survey Research Center on behalf of HHSC. You have been chosen at random to participate in the survey.

Your experiences and opinions are very important to the success of the survey. Participation is voluntary, and you do not need to answer any question you don't want to answer. There will be no negative consequences if you choose not to participate. Also, there will be no negative consequences no matter what you tell us during the survey.

The survey is conducted by telephone interview and will take about 30-45 minutes to complete. One of our interviewers will call you soon to ask you to take part in the interview. Our records show that your phone number is (000) 000-0000. If this number is not correct and you wish to participate or if you have any questions, **please call the Survey Research Center at 1-800-687-7055** to answer the survey or to give us your correct phone number so we can contact you. All calls to this number are free.

Thanks in advance for your help!

Sincerely,

A handwritten signature in black ink that reads "Paul Ruggiere". The signature is written in a cursive style with a long horizontal flourish extending to the right.

Paul Ruggiere, Ph.D.
Director
Survey Research Center

Pre-notification Letters for Parents of Youth Under Age 18 without a Telephone Number on Record



SURVEY RESEARCH CENTER

<<DATE>>

<<MERGE FIELDS>>

Dear Parent or Guardian:

We need your help. The University of North Texas Survey Research Center is conducting an important survey about the health care needs of children, and teenagers, and the health services they use. We're especially interested in your experiences with health care providers and with «Agency_name».

This survey is very important because it will help policy makers decide how to improve health services for young people with experiences similar to yours. This is your chance to help this agency serve you better.

This survey is funded by the Texas Health and Human Services Commission (HHSC). It is being conducted by the Survey Research Center on behalf of HHSC. You have been chosen at random to participate in the survey.

Your experiences and opinions are very important to the success of the survey. Participation is voluntary, and you do not need to answer any question you don't want to answer. There will be no negative consequences if you choose not to participate. Also, there will be no negative consequences no matter what you tell us during the survey.

The survey is conducted by telephone interview and will take about 30-45 minutes to complete. We did not have your phone number in our records. If you are willing to participate, **please call the Survey Research Center at 1-800-687-7055** to answer the survey or set up a time for us to contact you. All calls to this number are free.

Thanks in advance for your help!

Sincerely,

A handwritten signature in black ink that reads "Paul Ruggiere". The signature is written in a cursive style.

Paul Ruggiere, Ph.D.
Director
Survey Research Center

Pre-notification Letters for Youth Ages 18-21 with a Telephone Number on Record (Reduced to Fit Page)



SURVEY RESEARCH CENTER

<<DATE>>

<<MERGE FIELDS>>

Dear Mr./Ms. <<LASTNAME>>:

We need your help. The University of North Texas Survey Research Center is conducting an important survey about the health care needs of young people in your age group, and the health services they use. We're especially interested in your experiences with health care providers and with «Agency_name»..

The survey is very important because it will help policy makers decide how to improve health services for young people with experiences similar to yours. This is your chance to help this agency serve you better.

The survey is funded by the Texas Health and Human Services Commission (HHSC). It is being conducted by the Survey Research Center on behalf of HHSC. You have been chosen at random to participate in the survey.

Your experiences and opinions are very important to the success of the survey. Participation is voluntary, and you do not need to answer any question you don't want to answer. There will be no negative consequences if you choose not to participate. Also, there will be no negative consequences no matter what you tell us during the survey.

The survey is conducted by telephone interview and will take about 30 minutes to complete. One of our interviewers will call you soon to ask you to take part in the interview. Our records show that your phone number is (000) 000-0000. If this number is not correct and you wish to participate or if you have any questions, **please call the Survey Research Center at 1-800-687-7055** to answer the survey or to give us your correct phone number so we can to contact you. All calls to this number are free.

Thanks in advance for your help!

Sincerely,

A handwritten signature in black ink that reads "Paul Ruggiere". The signature is written in a cursive style.

Paul Ruggiere, Ph.D.
Director
Survey Research Center

Pre-notification Letters for Youth Ages 18-21 for whom HHSC does not have a Telephone Number



SURVEY RESEARCH CENTER

<<DATE>>

<<MERGE FIELDS>>

Dear Mr/Ms. [LASTNAME]:

We need your help. The University of North Texas Survey Research Center is conducting an important survey about the health care needs of young people in your age group, and the health services they use. We're especially interested in your experiences with health care providers and with [PROGRAM NAME].

The survey is very important because it will help policy makers decide how to improve health services for young people with experiences similar to yours. This is your chance to help this agency serve you better.

The survey is funded by the Texas Health and Human Services Commission (HHSC). It is being conducted by the Survey Research Center on behalf of HHSC. You have been chosen at random to participate in the survey.

Your experiences and opinions are very important to the success of the survey. Participation is voluntary, and you do not need to answer any question you don't want to answer. There will be no negative consequences if you choose not to participate. Also, there will be no negative consequences no matter what you tell us during the survey.

The survey is conducted by telephone interview and will take about 30 minutes to complete. We did not have your phone number in our records. If you are willing to participate, **please call the Survey Research Center at 1-800-687-7055** to answer the survey or set up a time for us to contact you. All calls to this number are free.

Thanks in advance for your help!

Sincerely,

A handwritten signature in black ink, appearing to read "Paul Ruggiere", with a stylized flourish at the end.

Paul Ruggiere, Ph.D.
Director
Survey Research Center

Spanish Versions

Survey of Youth Under Age 18⁷⁸

HHS_1

No fue difícil que [Fname] consiga los beneficios or servicios que[Fname] necesitaba de [INSERT PROGRAM AND AGENCY NAME].

1. DE ACUERDO
2. ALGO DE ACUERDO
3. ALGO EN DESACUERDO
4. EN DESACUERDO
98. DON'T KNOW
99. REFUSED

HHS_1

Fue razonable el tiempo que [Fname] esperó para recibir beneficios or servicios de [INSERT PROGRAM AND AGENCY NAME].

1. DE ACUERDO
2. ALGO DE ACUERDO
3. ALGO EN DESACUERDO
4. EN DESACUERDO
98. DON'T KNOW
99. REFUSED

HHS_1

En total, estoy satisfecho(a) con los beneficios o servicios que recibio [Fname] de [INSERT PROGRAM AND AGENCY NAME]

1. DE ACUERDO
2. ALGO DE ACUERDO
3. ALGO EN DESACUERDO
4. EN DESACUERDO
98. DON'T KNOW
99. REFUSED

⁷⁸ These agency-specific questions are part of a larger survey about how well available services meet the needs of CHSCN. The larger survey is an adapted version of two surveys used nationally: the National Survey of Children with Special Health Care Needs and the PedsQL. The survey was conducted by the University of North Texas Survey Research Center. It is anticipated that the report will be available late in the summer of 2010.

Survey of Youth Ages 18-21

Primero tengo algunas preguntas sobre los servicios que [fname/usted] recibio de [INSERT PROGRAM AND AGENCY NAME]

HHS_1

Contesten por favor con la respuesta que describe mejor su opinión. Fue difícil para [fname/mi] conseguir los beneficios or servicios que [fname/yo] necesitaba de [INSERT PROGRAM AND AGENCY NAME]

1. DE ACUERDO
2. ALGO DE ACUERDO
3. ALGO EN DESACUERDO
4. EN DESACUERDO
98. Don't know
99. Refused

HHS_1 Fue razonable el tiempo que [fname/yo] espere/ó para recibir beneficios or servicios de [INSERT PROGRAM AND AGENCY NAME]

1. DE ACUERDO
2. ALGO DE ACUERDO
3. ALGO EN DESACUERDO
4. EN DESACUERDO
98. Don't know
99. Refused

HHS_1

En total, [fname/yo estoy] satisfecho(a) con los [esta] beneficios o servicios que recibí/o [yo] del [INSERT PROGRAM AND AGENCY NAME]

1. DE ACUERDO
2. ALGO DE ACUERDO
3. ALGO EN DESACUERDO
4. EN DESACUERDO
98. Don't know
99. Refused

**Pre-notification Letters for Parents of Youth Under Age 18 with a Telephone Number on Record
(Reduced to Fit Page)**



SURVEY RESEARCH CENTER

El día 5 de mayo de 2010

Estimado Padre o Guardian:

Necesitamos su ayuda. El Centro de investigación por encuesta de la universidad del norte de Texas está conduciendo una encuesta importante sobre las necesidades de la salud de los niños y adolescentes, y de los servicios médicos que utilizan. Estamos especialmente interesados en sus experiencias con los proveedores de asistencia médica y con «AgencySpanish».

Esta encuesta es muy importante porque ayudará a los diseñadores de las políticas a decidir cómo mejorar los servicios médicos para los adultos jóvenes con las experiencias similares a las suyas. Ésta es su oportunidad de ayudar a esta agencia para servirle a usted mejor.

Esta encuesta es financiada por La Comisión de salud y de Servicios humanos de Texas (HHSC). Está siendo conducida por el centro de investigación por encuesta de parte de HHSC. Usted ha sido elegido al azar para participar en la encuesta.

Sus experiencias y opiniones son muy importantes para el éxito de la encuesta. La participación es voluntaria, y usted no necesita contestar ninguna pregunta que usted no quiera contestar. No habrá consecuencias negativas si usted elige no participar. También, no habrá consecuencias negativas por lo que usted nos diga durante la encuesta.

La encuesta es conducida por teléfono y se tomara cerca de 30 a 45 minutos para terminar. Uno de nuestros entrevistadores le llamará muy pronto para pedirle que usted participe en la entrevista. Nuestros expedientes muestran que su número de teléfono es (000) 000-0000. Si este número no está correcto y usted desea participar o si usted tiene cualquiera otra pregunta, **llame por favor al Centro de investigación por encuesta al 1-800-687-7055** para contestar a la encuesta o para darnos su número de teléfono correcto así podemos ponernos en contacto con usted. Todas las llamadas a este número son gratis.

¡Gracias por adelantado por su ayuda!

Sinceramente,

A handwritten signature in black ink, appearing to read "Paul Ruggiere", written in a cursive style.

Paul Ruggiere, Ph.D.

Director

Survey Research Center

Pre-notification Letters for Parents of Youth Under Age 18 without a Telephone Number on Record (Reduced to Fit Page)



SURVEY RESEARCH CENTER

El día 29 de abril de 2010

Estimado Padre o Guardian:

Necesitamos su ayuda. El Centro de investigación por encuesta de la universidad del norte de Texas está conduciendo una encuesta importante sobre las necesidades de la salud de los niños y adolescentes, y de los servicios médicos que utilizan. Estamos especialmente interesados en sus experiencias con los proveedores de asistencia médica y con cuidado sustituto bajo «AgencySpanish».

Esta encuesta es muy importante porque ayudará a los diseñadores de las políticas a decidir cómo mejorar los servicios médicos para los adultos jóvenes con las experiencias similares a las suyas. Ésta es su oportunidad de ayudar a esta agencia para servirle a usted mejor.

Esta encuesta es financiada por La Comisión de salud y de Servicios humanos de Texas (HHSC). Está siendo conducida por el centro de investigación por encuesta de parte de HHSC. Usted ha sido elegido al azar para participar en la encuesta.

Sus experiencias y opiniones son muy importantes para el éxito de la encuesta. La participación es voluntaria, y usted no necesita contestar ninguna pregunta que usted no quiera contestar. No habrá consecuencias negativas si usted elige no participar. También, no habrá consecuencias negativas por lo que usted nos diga durante la encuesta.

La encuesta es conducida por teléfono y se tomara cerca de 30 a 45 minutos para terminar. No teníamos su número de teléfono en nuestros expedientes. Si usted está dispuesto a participar por **favor llame al Centro de Investigación por encuesta al 1-800-687-7055** para contestar la encuesta o para hacer una cita con nosotros para ponernos en contacto con usted. Todas las llamadas a este número son gratis.

¡Gracias por adelantado por su ayuda!

Sinceramente,

A handwritten signature in black ink that reads "Paul Ruggiere". The signature is written in a cursive style.

Paul Ruggiere, Ph.D.
Director
Survey Research Center

Pre-notification Letters for Youth Ages 18-21 with a Telephone Number on Record (Reduced to Fit Page)



SURVEY RESEARCH CENTER

El día 24 de marzo de 2010

[Salutation]

Necesitamos su ayuda. El Centro de investigación por encuesta de la universidad del norte de Texas está conduciendo una encuesta importante sobre las necesidades de la salud de los adultos jóvenes en su categoría de edad, y de los servicios médicos que utilizan. Estamos especialmente interesados en sus experiencias con los proveedores de asistencia médica y con cuidado sustituto bajo «AgencySpanish».

Esta encuesta es muy importante porque ayudará a los diseñadores de las políticas a decidir cómo mejorar los servicios médicos para los adultos jóvenes con las experiencias similares a las suyas. Ésta es su oportunidad de ayudar a esta agencia Para servirle a usted mejor.

Esta encuesta es financiada por La Comisión de salud y de Servicios humanos de Texas (HHSC). Está siendo conducida por el centro de investigación por encuesta de parte de HHSC. Usted ha sido elegido al azar para participar en la encuesta.

Sus experiencias y opiniones son muy importantes para el éxito de la encuesta. La participación es voluntaria, y usted no necesita contestar ninguna pregunta que usted no quiera contestar. No habrá consecuencias negativas si usted elige no participar. También, no habrá consecuencias negativas por lo que usted nos diga durante la encuesta.

La encuesta es conducida por teléfono y se tomara cerca de 30 minutos para terminar. Uno de nuestros entrevistadores le llamará muy pronto para pedirle que usted participe en la entrevista. Nuestros expedientes muestran que su número de teléfono es (000) 000-0000. Si este número no está correcto y usted desea participar o si usted tiene cualquiera otra pregunta, **llame por favor al Centro de investigación por encuesta al 1-800-687-7055** para contestar a la encuesta o para darnos su número de teléfono correcto así podemos ponernos en contacto con usted. Todas las llamadas a este número son gratis.

¡Gracias por adelantado por su ayuda!

Sinceramente,

A handwritten signature in black ink that reads "Paul Ruggiere". The signature is written in a cursive style with a long, sweeping underline.

Paul Ruggiere, Ph.D.
Director
Survey Research Center



SURVEY RESEARCH CENTER

El día 4 de abril de 2010

[Salutation]

Necesitamos su ayuda. El Centro de investigación por encuesta de la universidad del norte de Texas está conduciendo una encuesta importante sobre las necesidades de la salud de los adultos jóvenes en su categoría de edad, y de los servicios médicos que utilizan. Estamos especialmente interesados en sus experiencias con los proveedores de asistencia médica y con cuidado substituto bajo «AgencySpanish»..

Esta encuesta es muy importante porque ayudará a los diseñadores de las políticas a decidir cómo mejorar los servicios médicos para los adultos jóvenes con las experiencias similares a las suyas. Ésta es su oportunidad de ayudar a esta agencia Para servirle a usted mejor

Esta encuesta es financiada por La Comisión de salud y de Servicios humanos de Texas (HHSC). Está siendo conducida por el centro de investigación por encuesta de parte de HHSC. Usted ha sido elegido al azar para participar en la encuesta.

Sus experiencias y opiniones son muy importantes para el éxito de la encuesta. La participación es voluntaria, y usted no necesita contestar ninguna pregunta que usted no quiera contestar. No habrá consecuencias negativas si usted elige no participar. También, no habrá consecuencias negativas por lo qué usted nos diga durante la encuesta.

La encuesta es conducida por teléfono y se tomara cerca de 30 minutos para terminar. No teníamos su número de teléfono en nuestros expedientes. Si usted quiere participar. Si usted está dispuesto a participar por favor llame al Centro de Investigación por encuesta al 1-800-687-7055 para contestar la encuesta o para hacer una cita con nosotros para ponernos en contacto con usted. Todas las llamadas a este número son gratis.

¡Gracias por adelantado por su ayuda!

Sinceramente,

A handwritten signature in black ink that reads "Paul Ruggiere". The signature is written in a cursive style with a long, sweeping underline.

Paul Ruggiere, Ph.D.
Director
Survey Research Center