HOUSE COMMITTEE ON HUMAN SERVICES
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2006

A REPORT TO THE
HOUSE OF REPRESENTATIVES
80TH TEXAS LEGISLATURE

SUZANNA GRATIA HUPP
CHAIRMAN

COMMITTEE CLERK
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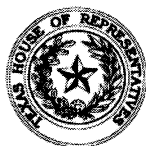

Committee On
Human Services

November 27, 2006

Suzanna Gratia Hupp
Chairman

P.O. Box 2910
Austin, Texas 78768-2910

The Honorable Tom Craddick
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Committee on Human Services of the Seventy-Ninth Legislature hereby submits its interim report including recommendations for consideration by the Eightieth Legislature.

Respectfully submitted,

Suzanna Gratia Hupp

Rob Eissler, Vice Chair

Toby Goodman

Elliott Naishtat

Elvira Reyna

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Governor Perry's Executive Order RP39

Executive Order RP39 - January 6, 2005
Relating to the immediate creation a Division of Investigations within the Department of Family and Protective Services by the Health and Human Services Commission.
BY THE GOVERNOR OF THE STATE OF TEXAS
Executive Department
Austin, Texas
January 6, 2005

WHEREAS, government has no greater responsibility than ensuring the safety of its citizens, especially the safety of its children; and

WHEREAS, as Governor, I issued Executive Order RP-35 on July 2, 2004, calling for a systemic review of the Child Protective Services program by the Health and Human Services Commission (H.H.S.C.) in response to concerns that the Child Protective Services (C.P.S.) program was failing to protect abused and neglected children; and

WHEREAS, the H.H.S.C. Office of Inspector General's findings, policy workgroups, stakeholder forums, and an employee survey all concluded that:

the C.P.S. program is not sufficiently focused on its core function of investigating allegations of abuse and neglect to protect children;
the integration of policy development, management, and direct practice for investigations with all other C.P.S. services in the state office and throughout the regions limits the focus and resources available to deal with emergent investigation problems and needed reform;
investigative caseworkers are working under a chain of command that is unable to assist them with making good decisions about their investigations; and

WHEREAS, Child Protective Services investigations are critical in determining whether child abuse or neglect has occurred and in protecting children from harm; and

WHEREAS, upon completion of that review, the Office of Inspector General found that in more than half of the investigations where action was needed caseworkers either failed to maintain contact with the child, failed to review the case with their supervisor for appropriate direction, or failed to provide all needed services to children; and

WHEREAS, failed investigations have left children in dangerous situations and contributed to a number child deaths;

NOW, THEREFORE, I, Rick Perry, Governor of Texas, by virtue of the power and authority vested in me by the Constitution and laws of the State of Texas as the Chief Executive Officer, do hereby order the following:

Creation. Health and Human Services Commission shall immediately create a Division of

Investigations within the Department of Family and Protective Services (D.F.P.S.) to place strong policy and management emphasis upon improved investigation methodologies.

Responsibilities. The Division of Investigations shall:

Receive, screen, and investigate reports of abuse and neglect, and
Refer families and children that need further services to appropriate D.F.P.S. or private sector providers in their communities.

Administration. Department of Family and Protective Services shall hire a director who has a strong background in forensic investigation and law enforcement to manage the C.P.S. Division of Investigations.

This executive order supersedes all previous orders in conflict or inconsistent with its terms and shall remain in effect and in full force until modified, amended, rescinded, or superseded by me or by a succeeding Governor.

Given under my hand this the 6th day of January, 2005.

RICK PERRY
Governor

ATTESTED BY:
GEOFFREY S. CONNOR
Secretary of State

INTRODUCTION

At the beginning of the 79th Legislature, the Honorable Tom Craddick, Speaker of the Texas House of Representatives, appointed nine members to the House Committee on Human Services. The Committee membership included the following: Chairman Suzanna Gratia Hupp, Vice-Chairman Rob Eissler, Toby Goodman, Elliott Naishtat, Elvira Reyna, CBO John Davis, Ken Paxton, Alma Allen, and Yvonne Gonzalez-Toureilles.

The House Committee on Human Services entered the 79th Legislative Session with a specific focus on making major reforms to the Child Protective Services program in Texas. Strengthening investigations in CPS was one of the top priorities for members and agencies alike, drawing attention to issues such as false reports of child abuse and reducing response time on abuse reports. At the forefront of the reform as well, was caseload reduction and documentation. Some caseworkers were reported to be handling up to 100 cases at a time.

These sorts of reforms not only needed to be addressed in the Child Protective Services program, but in the Adult Protective Services program as well. Across the board, widespread problems were documented in the State's existing systems for protecting children and vulnerable adults from abuse and neglect.

After hearing countless testimony from agencies under the Health and Human Services Commission, and other resources in the legislative, executive, and judicial branches of State government, Senate Bill 6, by Senator Jane Nelson and Chairman Suzanna Hupp, finally passed, containing provisions which affect all Department of Family and Protective Services agency programs: Child Protective Services (CPS), Adult Protective Services (APS), Child Care Licensing (CCL), and Purchased Client Services (PCS).

The following are key provisions in the bill:

CPS/APS Provisions

Strengthen Investigations:

- A **Director of Investigations** has been hired to oversee and direct the investigative functions of CPS.

- **Experienced Staff for Complex Cases (Senior Investigators)**
    - A new system will ensure that complex CPS investigations are assigned to staff with forensic investigation experience.

- **Response Time Reduction**
    - No later than September 2007, DFPS must immediately respond to a report that could lead to death or severe harm to a child. Highest priority reports must be responded to within 24 hours. All other reports must be responded to within 72 hours.

- **False Reports**
  - The penalty for a false report, with intent to deceive, will increase from a misdemeanor to a felony, with an increased penalty for previous offenders.

Support Quality Casework:

- **Caseload Reduction**
  - By the end of the biennium, CPS caseloads will drop from an average of 44 daily to an average of 33.
  - DFPS will develop a caseworker replacement program to ensure caseworker vacancies are filled in a timely manner.

- **Casework Documentation**
  - CPS caseworkers will identify investigative actions that impact child safety and document those actions in the child's file before the end of the next business day.
  - CPS Caseworkers will identify forms and paperwork that family members may assist in completing. The DFPS employee will be responsible for ensuring that the paperwork is completed appropriately.

Improve Services to Vulnerable Texans:

- **Child Placement**
  - The Relative and Other Designated Caregiver Placement Program will promote continuity for children in DFPS care and facilitate relative placement by providing assistance and services to caregivers.
  - The Child Placement Resources Form will be developed to ensure faster placement of children removed from the home. Parents will complete the form with three names of relatives or designated caregivers for a child in the event that a court orders the removal of the child.
  - DFPS will conduct background and criminal history checks on the relatives or other individuals identified as potential caregivers. DFPS must evaluate each individual listed on the form to determine the most appropriate substitute caregiver.

- **Attorney Ad Litem**
  - Requires attorneys ad litem to meet the child (or the child's caregiver, if the child is younger than four) before each court hearing and to obtain continuing education training in child advocacy.

- **Child Care Licensing**
  - Fines and penalties are strengthened for violations that occur in residential facilities.
  - Qualifications are laid out for persons eligible for child-placing agency administrators license.
  - Increases the minimum amount of continuing education required for licensed administrators.

- Child care facility staff will receive training on recognizing child abuse and sexual molestation, first aid, and preventing the spread of communicable diseases.
- Random inspections will be conducted in agency foster homes and group homes using an inspection checklist. The checklist will be provided to the facility upon completion of the inspection.
- Requires residential child-care facilities to notify parents earlier if DFPS decides to take adverse action against the facility's license.
- Requires facilities to report all serious incidents that threaten the health, safety, or well-being of any child, including missing children, to Child Care Licensing.
- Requires residential child-care facilities to report abuse by a child against another child.
- Includes the definition of a "controlling person" in a residential facility. If adverse action were taken against a facility, the ability of those people in the facility who are identified as controlling may be limited or prohibited from participating in residential child care.
- Changes the way a residential child-care license is issued. The criterion that the facilities must be "nearby" one another is replaced with more specific criteria.
- Requires a residential child-care employee from providing direct care or from having direct access to a child in care before a background check is complete.
- Requires residential child-care facilities to have a drug-testing policy.
- Allows CCL to prohibit reapplication by a person or entity following a denial or revocation from two to five years for a residential child-care facility.
- Allows CCL to prohibit reapplication by a person or entity following a denial for two years for a child day care operation.
- Allows CCL to deny a residential license to an applicant that has had a residential child-care facility license revoked in another state or if the applicant was barred from operating a residential child-care facility in another state.
- Increases training requirements for investigation staff and requires DFPS to provide advanced training in investigative protocols and techniques to residential child-care facility licensing investigators.

- **Health and Education Passports**
  - An electronic health passport and education passport will be created for every foster child. The health passport will contain medical history information and the education passport will contain educational records.
  - The passports will become part of DFPS records and will remain with the child while in the care of DFPS.

- **Preparation for Adult Living** (PAL)
  - DFPS will help foster children facing the challenge of transitioning to independent living.
  - Foster care eligibility and transition services will be extended to foster youth up to age 22.

Build Community Partnerships:

- **Working with Law Enforcement**
  - DFPS will collaboratively work with law enforcement to conduct joint investigations. Investigations will incorporate the use of forensic methods for determining the occurrence of abuse and neglect.
  - Joint training will also be conducted to improve interviewing techniques, evidence gathering, and testifying in court for criminal investigations.
  - Collocation with law enforcement will improve the efficiency of child abuse investigations.

- **Cultural Awareness**
  - Cultural competency training will be given to all direct delivery staff.
  - The disproportionate representation of any ethnic or racial group will be studied, analyzed and reported to the Legislature.

Improve Management and Accountability:

- **Outsourcing Case Management and Substitute Care Services**
  - The outsourcing of case management and substitute care services will be completed on a regional basis. The first region will be completed by December 31, 2007.
  - A second and third region will be implemented by December 31, 2009.
  - After September 1, 2011 DFPS may provide substitute care and case management services in an emergency.

- **Enhanced Technology**
  - Mobile technology (tablet PC's) will be developed for use by CPS investigation caseworkers to increase efficiency and allow for daily documentation.
  - The strategic use of technology will continue to be explored as a way of reducing workload, increasing accountability, and enhancing overall efficiency and effectiveness.

Prevent Maltreatment:

- **Prevention and Early Intervention**
  - Health and Human Services Commission and DFPS will develop a plan to combine funds with appropriate state agencies and government entities to provide services to prevent children from being placed in foster care. The services may include counseling, parenting skills instruction, support services, crisis services, and more.
  - The Community-Based Family Services grant program will be established to provide funding to community organization that respond to and help prevent child abuse.
  - The family protection fee, collected when a couple files for divorce, is established with half of the fee going to the child abuse prevention trust fund and half of the fee going to counties for prevention programs.

- Funds county child abuse prevention programs with fines assessed against persons convicted of certain sexual assault offenses.

•Drug-Related Initiatives

- The Family Drug Court Program will integrate substance abuse treatment services into child abuse/neglect cases, when necessary.
- The Drug-Endangered Child Initiative will be established to help protect children who are exposed to methamphetamine production.

Policy and Procedures

- **Guardianship Program Transfer**
    - The Guardianship Program is transferred to the Department of Aging and Disability Services.
    - The transfer will allow DFPS to focus on its investigative function, identifying cases of abuse, neglect, and exploitation.

- APS will develop and implement a **quality assurance program** for services provided to APS clients.

- APS shall maintain an **investigation unit** to investigate allegations of abuse, neglect, and exploitation of elderly and disabled persons.

- **Experienced Staff for Complex Cases**
    - A new system will ensure that complex APS investigations are assigned to the most experienced staff.

- **Assessment of Ability**
    - DFPS will ensure that only trained professionals will assess a person's decision-making capacity when the person is in a state of abuse, neglect or exploitation that may pose a threat to life or physical safety.

Organization and Administration

- **Caseload Reduction**
    - By the end of the biennium, APS caseloads will drop from an average of 35 daily to an average of 28.
    - DFPS will develop a caseworker replacement program to ensure caseworker vacancies are filled in a timely manner.
    - DFPS will develop a recruitment program that encourages qualified applicants to apply for direct practice positions.
    - DFPS will offer an incentive program to encourage retention of qualified staff.

- **Enhanced Training for APS Workers**
    - Enhanced training will include additional field training, use of risk assessment tools, available legal procedures, best practices for case management, and actual case examples, including specialized training in financial exploitation, self-neglect and working with community organizations, law enforcement, and courts.
    - On-the-job training will require supervisors to accompany workers throughout their first case.

- **Enhanced Technology**
    - APS caseworkers will receive state of the art technology tools, such as tablet PCs, to increase efficiency.
    - The strategic use of technology will continue to be explored as a way of reducing workload, increasing accountability, and enhancing overall efficiency and effectiveness.

Working with Community Partners

- APS will implement a statewide **public awareness campaign** to educate the public about abuse, neglect, and exploitation of elderly and disabled people.

- APS will work with special task units that will exist in counties with a population that exceeds 250,000. The task units will work together with APS caseworkers and supervisors to resolve complex cases. [1]

The final product of Senate Bill 6 was a result of many labor intensive hours dedicated by Executive Commissioner Albert Hawkins and Deputy Executive Commissioner Anne Heiligenstein and staff, of HHSC; Commissioner Carey Cockerell and staff, of DFPS; Commissioner Adelaide Horn and staff, of DADS; Governor's and Speaker's staff; Brian Flood of HHSC's Office of Inspector General and staff; Senator Jane Nelson and staff; and finally, all of the committee members of the House Committee on Human Services and their staff. Texans will be forever grateful for all you and your hard work.

With some of the changes to Senate Bill 6 already in place, and some soon to be implemented, The Human Services Committee made its way into the interim with charges issued by the Speaker in one hand and a watchdog mentality in the other; preserving accountability for the reforms so avidly pushed in the 79th Legislature.

Speaker Craddick charged the committee with the following issues:

House Committee on Human Services
Interim Study Charges

CHARGE #1:
Examine ways foster care provides, or does not provide, preparation for adult living to foster children. Review programs other states have adopted to enhance the likelihood that foster care alumni will complete a secondary education or maintain trade skills learned while in foster care. Examine the correlation between the school drop-out pattern, job maintenance and poverty, and foster care preparation programs for adult living.

CHARGE #2:
Study the effectiveness, efficiency and funding mechanisms of mental health and mental retardation services. Identify and study best practices in crisis intervention, residential treatment and aftercare. Identify and study successful mental health services delivery models established by other states.

CHARGE #3:
Monitor how changes in the Food Stamp Program at the federal level affect participation in Texas, including proposed changes in the 2006 Federal Farm Bill.

CHARGE #4:
Monitor the agencies and programs under the committee's jurisdiction.

All charges were studied by the committee as a whole.

CHARGE #1:

Examine ways foster care provides, or does not provide, preparation for adult living to foster children. Review programs other states have adopted to enhance the likelihood that foster care alumni will complete a secondary education or maintain trade skills learned while in foster care. Examine the correlation between the school drop-out pattern, job maintenance and poverty, and foster care preparation programs for adult living.

BACKGROUND:

Poverty, homelessness, victimization, criminal involvement, low educational attainment, emotional problems, and dysfunctional relationships. These, to name a few, are problems youth are at extreme risk to face as they transition out of the foster care system; ill prepared for social and economic responsibilities. [2] Foster youth tend to experience a sense of being clumped together and long for individualized treatment and attention.

A Northwest Foster Care Alumni Study, which reviewed case records of alumni from Oregon and Washington State, found that a disproportionate number of alumni had **mental health problems.**

- Within a time period of 12 months, more than half of the alumni (54.4%) had clinical levels of at least one mental health problem, such as depression, social phobia, panic syndrome, post-traumatic stress disorder, or drug dependence, and one in five (19.9%) had three or more mental health problems. These rates, according to the study, are substantially higher than those of the general population in the age range of the sample.
- Post-traumatic stress disorder (PTSD) rates for alumni were double that of what U.S. war veterans experienced. One in four alumni (25.2%) experienced PTSD within a 12 month time frame.
- Many alumni recovered from mental health problems. Although alumni encountered significant mental health problems, recovery rates for major depression, panic syndrome, and alcohol dependence were similar to those of the general population (recovery was defined as occurring when a previously diagnosed mental health illness had not been present in the past 12 months). While some recovery rates seem high, a substantial proportion of alumni is living with mental health problems.[3]

While this study was not conducted in Texas, the findings are imperative to the future of the Texas foster care system and its alumni. Many of the findings from the Northwest Foster Care Alumni Study were not just taken from the Northwest part of the country, but across the U.S. as well, and mirror the reported challenges alumni face in Texas today. A similar study, the Texas Foster Care Transitions Project, was conducted in 2001 by the Center for Public Policy Priorities and Casey Family Programs. Although somewhat outdated, it also provides some insight into youth phasing into independence. Both studies are key to improving the welfare of the future of

foster care alumni.

Lack of **educational attainment** among alumni is a resounding problem that can gateway into economic instability and in some cases incarceration. One of the biggest roadblocks for youth in foster care in continuing their education is loss of school credits. Many times, because of numerous placements in schools and homes, high school credits are not transferred along with the student, which forces them to start over again and again. Once more, the foster youth feels discouraged and unsuccessful.

The Northwest study found that alumni completed high school at a high rate.

- Over four in five alumni (84.8%) had completed high school via a diploma or a general educational development (GED) credential (89.1% among those 25 years and older). This compares favorably to the general population, (87.3%) but is much higher than graduation rates found by other foster care studies, and they used GED programs to complete high school at six times the rate of the general population.
- Completing high school via GED testing was found to be a common practice among alumni. Over one in four (28.5%) of the alumni who completed high school did so by passing GED tests; this is a concern because national research has found that adults with a diploma are 1.7 times more likely to earn an associate's degree and 3.9 times more likely to complete college. Adults with a high school diploma also earn more than those who have a GED credential.
- Alumni experienced **seven or more** school changes from elementary through high school (65%).
- Alumni completion rates for postsecondary education were low. Fewer than one in five alumni (16.1%) had completed a vocational degree; the rate was greater for alumni who were 25 years or older (21.9%). The rate for completing a bachelor's or higher degree (1.8%) was significantly lower than that of the general population of the same age (24%). The rate increased somewhat (to 2.7%) among alumni who were 25 years or older, but remained dramatically lower than that of the general population. [4]

A poor education structure and attainment, provides little or no foundation for a **stable economic future**, which is evident not only in the general population, but overwhelmingly in the foster care alumni population as well.

- Many alumni are in fragile economic situations. After accounting for alumni who were not in the workforce (e.g., full-time students and homemakers), the employment rate was 80.1%. This rate is lower than for 20- to 34-year-olds in the general population (95%). One-third of the alumni (33.2%) had household incomes at or below the poverty level, which is three times the national poverty rate. One-third (33.0%) had no health insurance, which is double the national rate of 18% for ages 18 to 44 years old. More than one in five alumni (22.2%) experienced homelessness after leaving foster care. [5]

Undoubtedly these results are staggering, and they are unfortunately inevitable. When youth reach 18 years old, they are released from their foster homes or residential facilities, whether or not they have a plan or living arrangements. As reported in the Northwest study, only 28.8% of

alumni exited foster care with 2 or 3 of the following items: a driver's license, $250 in cash, and/or dishes and utensils. [6] Scantily equipped with material necessities, alumni also have a disadvantage due to their lack of knowledge of general life skills.

These outcomes can be prevented by taking responsibility for youth while still living in care. Preventive methods confirm successful resolutions for youth who begin independent living. Ongoing, caring relationships with a positive role model also have a huge impact on youth. Seemingly easy to achieve, these relationships are often rare when youth commonly experience eight or more placements throughout their foster care years. [7]

What are the solutions?

Federal and state governments spend billions of dollars on child welfare services each fiscal year.[8] Money is being spent on a foster care system, that has not been well-executed, and does not examine all of the ways to prepare its alumni for a future in which they can give back to the system. Eventually, because of the lack of job skills, minimal schooling, and emotional trauma, alumni may end up back in the system, possibly dependant on welfare or incarcerated, costing the state more money. It is an endless cycle, but there are solutions.

Preparation for adult living

In keeping with the Northwest Alumni Study, and Casey Family Programs findings, recommendations should be separated into mental health, education, and employment. The study first examines what can be focused on in the mental health side of foster care and how this dovetails into education and eventual employment. Key findings:

Mental Health

PTSD and depression are prevalent among foster youth and alumni and create a barrier in everyday life. This proves the need to:

- Reform systems to improve Medicaid coverage through enhanced payments or other incentives to eligible mental health providers to ensure access for foster youth. Federal and state governments should examine barriers to mental health care — including eligibility requirements that limit access to funding and worker capacity that may be insufficient to treat mental health problems — so that youth and alumni have greater access to effective treatment.
- Provide specialized training to Medicaid-funded and other therapists to enable them to properly screen, assess, and treat PTSD, depression, social phobia, and other disorders.
- Expand early and ongoing evidence-based treatment to help alleviate mental health disorders.
- Treat youth with validated behavioral approaches, and validate promising new interventions. [9]

Placement stability in foster homes lays the foundation to emotional stability. The study found that continuous relationships with adults, preferably kin, lessens the likelihood that youth will run away or end up homeless. Strengthening the initial placement is encouraged, while training

the foster parent to handle child behavior management, minimizing placement disruptions. [10]

The cost of behavioral health care in Texas is 40 times higher for foster children than for Temporary Assistance for Needy Families (TANF) non-foster children. [11] The overuse of psychotropic medication in foster care youth can attribute to that rate. Concerns were raised regarding this overuse in a 2004 report released by the Office of the Inspector General, which prompted the Texas Health and Human Services Commission, Department of State Health Services, and the Department of Family and Protective Services to assess the problem and prescribe new guidelines to providers for the distribution of such medications. [12]

Important changes were made in the prescribing trends of psychotropic medications, causing trends to decrease in the 5 months following the release of the guidelines:

- **percentage of children taking two or more psychotropic medications at the same time decreased by 28.7%**
- **prescribing 5 or more medications at the same time decreased by 30.9%**
- **prescribing to children without a mental health diagnosis decreased by 21.8%**

Although the focus of the guidelines was to improve patient care, decreased prescribing may have led to decreased drug costs.

- **five months prior to the guidelines, the average Medicaid drug claims cost per foster child was $447**
- **five months after, the average cost per child was $405, *a decrease of 9.3%***
- **based on 30,491 children in Medicaid foster care from April-August 2005, this decrease per child equates to just over *$3 million in drug claims savings per year***

These savings figures are high level estimates, and do not take into account drug price inflation (which, if taken into account, likely would increase savings), seasonal changes in psychiatric care utilization (which likely would decrease savings), and drug rebates that Texas Medicaid receives from manufacturers (would decrease savings).

In order to continue the drop in behavioral health issues and dependence on psychotropic medication, the Texas Health and Human Services Commission is looking ahead to:

- develop strategies to understand the clinical needs of the patient.
- work with prescribers to see if treatment alternatives exist to reduce psychotropic medications.
- further implement a comprehensive health care model for foster children, including perfecting the medical passport program, which makes it easier for medical records to follow the foster care youth.
- create public awareness to foster youth and providers about psychotropic medications. [13]

Education

> ***Sense of Identity:***
> *Associated with*
> - *Positive interpersonal relationships*
> - *Psychological and behavioral stability*
> - *Productive adulthood.*
>
> *Adolescents' sense of competency, connectedness and control lead to their sense of self into a stable and consistent identity.*
>
> *Their self- concept becomes integrated into their understanding of society, making them feel part of the larger culture.*
>
> *Identity is formed when youth have:*
> - *An opportunity to become involved in community service*
> - *When they receive support for their future goals from family members, teachers, and friends*
> - *When they have opportunities to express and develop their own points of view in their families.*
>
> *(Teach them to Fish: Working with Youth in Transition from Foster Care Edmund S. Muskie School of Public Services, 7/25/2003)*

Foster youth generally graduate with a GED, followed by a year or two of vocational training, but rarely go on to finish their secondary education. What is the key for success?

While alumni are in care, they need to be encouraged to graduate with a high school diploma, as well as challenged to enter into college-prep programs, like Upward Bound, or Gear Up. [14] Preparing alumni with the proper resources to maintain independence as they pursue education is very important as well. Resources like basic tools, cash, driver's license, dishes and utensils are just a few of the common necessities. As discussed before, school changes are frequent among foster youth. A major effort should be made to minimize school placements, allowing for relationships to grow with other students and teachers, and supporting dedication to school activities. Also, the possibility for loss of school transcripts is less likely to occur, creating an easier entry into secondary education. These changes, along with support from agencies and a stable adult in the alumni's life, are all important when encouraging focus on education. [15]

Employment and Finances

Building healthy relationships between youth in foster care and the community cultivates a positive pathway as youth transition into adulthood; carrying with them a sense of identity, confidence, and security. These sociological traits are best suited if alumni are prepared to enter the job market. If faced with constant failure, those traits will inevitably disappear, and emotional distress once again rears its ugly head.

Life skills training is absolutely imperative for youth as they prepare for independent living. The Texas Department of Family and Protective Services, with the help of Casey Family Programs, has addressed the problems alumni face as they transition into adult living by creating the Preparation for Adult Living (PAL) program. After 20 years of implementation, the program continues to expand and improve. Prior to the PAL program, there was not a formalized state program to provide transitioning youth services.

PAL policy requires that youth 16 and older, who are in substitute care receive services to prepare them for adult living. With funding availability, regions may serve any youth 14 or older on whom Child Protective Services has an open case. PAL, in collaboration with public and private organizations, assists youth in identifying and developing support systems and housing for when they exit care. PAL gives youth skills and training, but most of all, it helps them realize that there are options. [16]

An initial assessment of each PAL participant is usually done around their 16th birthday to determine their general readiness to live independently. This also helps assess what training and

plans must be specifically developed for each youth. A post-assessment is then done two months after discharge from substitute care. Improvements on these assessments are currently being implemented by DFPS, by improving discharge planning services and caseworker training on discharge planning and resources to help ease the transition for youth leaving foster care. The agency has also been directed to expand support services for youth as they emancipate from foster care.

After receiving additional funding for the program in 1999, PAL services were expanded to include financial assistance for room and board, aftercare case management services and an Educational and Training Voucher program.

Counseling services for tobacco and/or alcohol abuse is required in the PAL Life Skills training classes and tailored to best meet an individual's needs. After the young person leaves foster care, assistance in locating continued counseling is in place for them.

PAL program improvements have most recently been a result of the CPS reform efforts. Although the program has always served young people up to the age of 21, the program now provides a means for youth to stay in foster care up to age 22 if enrolled in and regularly attending high school. Previously, youth had to graduate high school by age 20. Additionally, youth can now stay in foster care until age 21 to complete a Vocational/Technical program. Previously, youth had to complete the program by age 19.[17]

DFPS and Texas Workforce Commission continued improvements by signing a memorandum of understanding (MOU) to coordinate sharing of resources to assist youth aging out of foster care with employment related services. DFPS stated that "through this MOU, foster youth are now a priority population to be supported by workforce." Cross training between DFPS PAL Staff and Workforce Boards was provided in May of 2006.

Important resources for youth preparing for adult/independent living:

Independent Living Skills consist of:

- Personal and Interpersonal Skills
- Job Skills
- Housing and Transportation
- Health
- Planning for the Future
- Money Management

Support Services consist of:

- Vocational Assessment and/or Training
- GED Classes

- Preparation for College Entrance Exams
- Driver Education
- High School Graduation Expenses (if not available from another source)
- Counseling
- Volunteer Mentoring to Provide Guidance and Support[18]

DFPS now offers a handbook called the "Texas Foster Care Handbook for Youth." In the handbook, are perspectives from other youth, common terms and phrases used in the foster care system, frequently asked questions, information about the PAL program, information about college and more. The handbook was co-created by a DFPS youth leadership committee and will help other youth feel like they are not alone in their thoughts and questions. It will also serve as guide for caseworkers, foster parents, teachers, and those in the community.

The special needs of youth in foster care have begun to be realized. Changes and innovative programs have been examined and delivered, but expanding and improving those realizations are urgent.

Programs in other states

The U.S. Department of Labor fully funds the Job Corps program across the nation, which teaches students, many times at-risk youth, job and management skills, responsibility and communication, and how to create a career plan. [19] With four locations in Texas, Job Corps has been a useful tool to some foster youth, but its resources have not been fully tapped. Difficult entrance requirements for youth as a candidate for Job Corps have been a barrier; restrictive in many cases for the foster population. Special programs for foster youth could perhaps be created within Job Corps to ensure that no one is turned away, and their specific challenges are addressed. Recently, however the Department of Labor has issued program instruction, specially focusing in on the foster youth community, which directs local Job Corps centers to work with state youth advisory boards. Currently, 0.04% of Job Corps' students are listed as foster youth, but as outreach with local agencies intensifies, admissions numbers for this special community are expected to rise.

A six and twelve month follow-up on those placed in employment or military after leaving Job Corps is completed, which includes the percentage of those confirmed still working and their average weekly wages. Below is an example for PY '02, '03, and '04, as reported by the U.S. Department of Labor, Job Corps Annual Reports.

	PY 2002	PY 2003	PY 2004
6-mo follow-up/*wage*	62.7% */$353*	63.4% */$358*	66.2% */$370*
12-mo follow-up/*wage*	64.6% */$367*	65.8% */$377*	67.7% */Not Avail*

Because Job Corps is partially a residential program, working with the community, case workers, judges, local employers, and so on, is not only important in helping students gain access to the

program, but essential in helping students as they transition out of the program into their working lives. As mentioned previously, a constant adult figure in a foster youth's life is very important to their stability and success, and Job Corps is a program that facilitates this principle.

Connecticut's Program:

Connecticut's Department of Children and Families supports a prevention, intervention and transition program for troubled and foster youth in its state. The Wilderness School is a tuition fee program utilizing a significant private funding base and offers high impact wilderness programs intended to foster positive youth development. It is based upon the philosophies of experiential learning and is considered therapeutic for the participant. Studies have documented Wilderness School's effect upon adolescents in the related areas of self-esteem, personal responsibility, and interpersonal skill enhancement. [20] This is also intended to strengthen the relationship between the youth and the caseworker or referring agent. Follow-up contact is made from the Wilderness School to reinforce experiences learned while at the school. Most importantly, the following are required:

- Reunion: The Wilderness School Reunion, to which all alumni, agency staff, and family members are invited, is held each fall. Students will receive a notice of the Reunion for two years following their 20-Day, 5-Day or Alumni Expeditions.
- Student Follow-Up Courses: Short courses of one and two days in length are offered in the fall, winter, and spring for participants of 20-Day, 5-Day or Alumni Expeditions. Follow-Up courses include rock climbing, canoeing, backpacking, or caving opportunities. In the winter, students have the opportunity to experience new challenges such as snowshoeing, cross-country skiing, winter camping, and animal tracking.
- Student/Agent/Family Courses: Courses designed specifically to involve parents or guardians and other family members (13 years and above), and Referring Agents, are offered during the Follow-Up year. These usually involve hiking, group activities, snowshoeing or skiing, and tracking in the winter. **These courses are intended to support relationships between students and significant adults or family members.**
- Regional Follow-Up Courses: Wilderness School staff occasionally travel to program sites we have developed near major referring communities, e.g., Hartford, New Haven, and Stamford/Danbury. One-day courses may be conducted for students, agents, and parents, and are intended to bring greater accessibility to Wilderness School Follow-Up experiences. [21]

Because the program has been supported by the state, its outreach has been noticeable. Connecticut experiences low multiple placement rates (85% in custody shall experience no more than 3 placements during any 12-month period), and low re-entry rates into Department of Children and Families custody (No more than 7% of all children entering DCF custody shall re-enter care within 12 months of a prior out-of-home placement). The DCF also has a website available, targeted toward foster care youth, called "The National Network for Foster Children and Foster Youth: FosterClub, USA." [22] This website encourages the "3 Is:" Involved, Informed, and Independent. **This is one example of a poll the website featured for the week**:

Have you ever "snuck" a visit or phone call to your bio family members, even though you weren't suppose to? Would you if you could? *all answers are confidential*

62% say "I have!"

22% say "I would if I could figure out how!"

16% say "I have not and would not!"

This website is a place where foster youth can go to chat with their peers, who relate to them and their issues, as well as a place to ask questions and formulate an understanding of their situation.

These programs build themselves around one key dynamic: social interaction. As long as these foster
youth and alumni feel like they are a part of something important and ongoing, they have an incentive to strive for more.

CONCLUSION:

When leaving the safety-net of their parents' home, most 18-year-olds head to college with some apprehension, but mostly anticipation for social activities, new relationships, escaping curfews, and complete independence. Most though, aren't completely independent. They still have their parents to fall back on for gas money and laundry services. But most of all, they still have their parents' support when things get to hard to cope with.

This is a completely different story for 18-year-olds in foster care who are suddenly faced with independence, staring at possible homelessness, poverty, health and mental health problems, and desertion. The gap can be narrowed between these two groups by optimizing specific foster care experiences, including Placement History and Experience, Education Services and Experience, and Resources upon Leaving Care, creating better outcomes. [23]

<u>Placement History and Experience</u>
Road to success: low number of placements; short length of stay in care; low number of placement changes per year; and no reunification failures, runaway episodes, or unlicensed living situations with friends or relatives. [24]

- Results for the Northwest Study showed that statistical optimization of this area reduced estimated negative education outcomes of alumni by 17.8% and reduced estimated negative mental health outcomes by 22.0%.

<u>Education Services and Experience</u>
Road to success: few school changes and access to supplemental education resources. [25]

- Results for the Northwest Study showed that statistical optimization of this area reduced estimated negative mental health outcomes by 13.0%.

Resources upon Leaving Care (leads to better preparation for independent living)
Road to success: having at the time of exit resources like one time cash assistance, dishes and utensils, and a driver's license. [26]

- Results for the Northwest Study showed that statistical optimization of this area reduced estimated negative education outcomes by 14.6% and reduced estimated negative employment and finance outcomes by 12.2%.

Small improvements in segmented areas of foster care, and an accessible network in the community make a lasting positive impact on alumni. Once youth leave the system as "adults," they cannot be set aside or forgotten. Given the right equipment, both psychologically and physically, they have the power to invest into the system that invested in them.

CHARGE #2:

Study the effectiveness, efficiency and funding mechanisms of mental health and mental retardation services. Identify and study best practices in crisis intervention, residential treatment and aftercare. Identify and study successful mental health services delivery models established by other states.

BACKGROUND:

In a speech announcing the creation of the President's New Freedom Commission, in Albuquerque, New Mexico, on April 29, 2002, President George W. Bush stated that, "Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care. They deserve a health system that treats their illness with the same urgency as a physical illness." [27]

As a result, the President's commission, recommended that the "Nation must replace unnecessary institutional care with efficient, effective community services that people can count on. It needs to integrate programs that are fragmented across levels of government and among many agencies, [...and improve upon how] mental health care is delivered in America."

Mental illness strikes more Americans each year than any other serious illness. It is an illness however, that can be treated and recovery is possible. A well-funded, accessible, and stable mental health system is necessary for the road to treatment and recovery by providing critical services before an individual with a mental illness is forced into crisis.

> "A successful system focuses on consumers' functional improvement and/or recovery through the delivery of evidenced-based practices for both adults and children."
> **- Mental Health Association of Greater Houston**

The Department of State Health Services (DSHS) and The Department of Aging and Disability Services (DADS), along with law enforcement, education, Medicaid, CHIP, the criminal justice system, hospitals and other entities, all make up the public mental health system in Texas. The collaborative effort of all of these entities has been crucial, as behavioral health issues impact each one of them individually and as a whole:

- **75% of children placed in foster care have parents with behavioral health problems**
- **75% of kids in the juvenile justice system have behavioral health problems**
- **30% of kids in the juvenile justice system will end up in the adult justice system**
- **46% of all ER visits have behavioral health issues as a basic or contributing factor; and**
- **30% of all truancy is related to behavioral health problems** [28]

DSHS oversees 40 community-based services, acting as Local Mental Health Authorities (LMHA),[29] the Dallas Area NorthSTAR Authority, and 180 substance abuse contracts, as well as 10 state hospitals.

Community MHMR Centers:

Regional coverage for mental health care in all 254 counties of Texas is in place as publicly supported community mental health centers provide information and referrals, psychiatric evaluations, 24-hour crisis intervention, medication support, impatient treatment, employment and vocational services, care coordination, family support and respite care, housing, supported living and residential services, as well as mobile services to the community. [30] Community MHMR Centers should be responsive to local government sponsoring agencies, therefore ensuring the mental health services needs in their area. Each center enters into a performance contract with DSHS and must fulfill the State's mission to promote "optimal health for individuals and communities." [31] Stipulations include the services targets, performance measures, outcomes and remedies, sanctions, and penalties that may result in failing to fulfill contract expectations. [32]

Dallas Area NorthSTAR Authority:

NorthSTAR provides behavioral healthcare for residents of Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties and offers an integrated care model, in which mental health and chemical dependency treatment are coordinated under behavioral health, allowing integrated treatment in a single system of care. [33]

Contractor services in the program create provider competition, which can lead to cost effective care and customer choice of provider. The separation of the authority (state) and the provider may allow the authority to act without being obligated to the provider, creating enhanced responsiveness to the consumer and government. Some feel this solid base model is the answer for Texas' behavioral health services delivery problems.

On the other hand, contrary testimony was given by the Chairman of the Board of Trustees of the community MHMR center, LifePath Systems, which serves as one of the providers in the NorthSTAR system. Dr. Ronald Crawford, Jr. stated that after seven years, the system continues to be unstable and suffers from a severe financial crisis. According to the Board, two of the five community centers in the system have been dissolved and the largest provider had to be taken over by the state. The Board has spent over $1.2 million to cover uncompensated care and is worried that they could be endangering their Mental Retardation and Early Childhood Intervention programs by continually expending reserves.

This may warrant a more in-depth look into the NorthSTAR challenges in order to accomplish a more efficient system in the future.

State Hospitals:

10 Mental health facilities provide inpatient hospitalization for persons with severe mental illness who need intensive treatment:

Austin State Hospital

Big Spring State Hospital
El Paso Psychiatric Center
Kerrville State Hospital
North Texas State Hospital
Rio Grande State Center/ South Texas Health Care System
Rusk State Hospital
San Antonio State Hospital
Terrell State Hospital
Texas Center for Infectious Disease
Waco Center for Youth

The state hospitals operated by DSHS are primarily acute care facilities that provide intensive, relatively short-term treatment for persons with severe mental illness. The only DSHS run psychiatric residential treatment facility is the Waco Center for Youth (WCY).

The average length of stay in the 10 state hospitals for patients is 34.5 days. The average length of stay in the 28 private psychiatric hospitals (designed to treat people who have diagnoses that would not make them eligible in state facility) is 9.2 days. [34]

The current recidivism rate in state hospitals, according to DSHS, is 50%, while 50% comprise new patients, with a waiting list of 7,000.

The Austin State Hospital experienced an 8.8% increase in admissions in one year. [35] Terrell State Hospital has been operating at 9.5% over capacity, serving about 300 patients per day as opposed to the optimum 274. [36] Psychiatric emergency rooms at Parkland Memorial Hospital in Dallas generally admit between 600 to 650 patients per month, but in a period of 18 to 24 months, the number of admissions averaged 900 per month.[37]

DSHS has begun to look at suicide prevention activities, which might assist in driving down numbers in psychiatric emergency rooms. Suicide rates and patterns in Texas are similar to those for the entire United States. The 2,355 deaths in Texas in 2003 made suicide the tenth leading cause of death, accounting for 1.5% of all deaths. The suicide rate for Texas (11 deaths per 100,000 persons) compares with a rate of 10.8 in the United States for 2003.[38]

Some of the DSHS prevention activities include:

- Appointment of a Suicide Prevention Officer.
- Applied for and received award for the SAMHSA-funded Youth Suicide Prevention grant. Harris County is the pilot site for this primary care and suicide prevention initiative. Travis and Bexar County will also receive suicide prevention training for key community and school leaders. These counties were selected due to their above national average suicide rates. This grant's target population is youth ages 10-21.
- Creation of the Educational Services Centers suicide prevention subcommittee to provide updated education for school personnel; and
- Formation of a DSHS Suicide Prevention Workgroup to examine current suicide

prevention practices across the agency and recommend ways to enhance existing practices and implement new ones.

The numbers of suicides from 2001 to 2003 have increased in Texas by 6%, with 141 more people who committed suicide in the two years. Current numbers on suicide in Texas were not available from DSHS, but trends suggest that suicide rates have continued to increase based on increases yearly since 2000.

Study the effectiveness, efficiency and funding mechanisms of mental health and mental retardation services.

Resiliency and Disease Management and Jail Diversion Strategies:

With the passage of House Bill 2292 in the 78th Legislature, 2003, came the integration of physical health and behavioral health, a mandate that LMHA's operate as a "provider of last resort,"[39] a directive to Community MHMR Centers to serve priority populations ,[40] and the implementation of Resiliency and Disease Management Services and jail diversion strategies. "The implementation of each," testified Joe Lovelace of the Texas Council of Community Mental Health and Mental Retardation Centers, "has reshaped the public mental health system and how community centers do business."

Resiliency and Disease Management (RDM) is an evidence-based model, which is intended to better match services to Mental Health consumers' needs, and to use limited resources most effectively by providing the right services to the right person in the right amount to have the best outcomes. It includes medication management, case management, skills training, family training, supports and partners, psychosocial rehabilitation, individual and group counseling, supported employment, supported housing, and Assertive Community Treatment (ACT). [41]

As a system of supports, RDM provides for efficient identification and treatment of patients with mental illnesses. RDM focuses on services that encourage recovery, including a standard means of evaluating the patient, establishing a formal diagnosis, and implementing a treatment plan that will stabilize the crises and assist the patient to take the correct steps toward recovery. [42]

Community centers are now required to meet performance and process measures and use new assessment tools; answering questions like, was the patient assessed properly? Is the patient receiving the level of service they need? The state monitors the information by collecting data for every service an individual receives within the community mental health system and then cross analyzes the data to determine the appropriateness and effectiveness of services at each center and throughout the system. Failure to meet the requirements of the contract could result in real contract sanctions up to $250,000 in a single quarter, ensuring accountability. [43] Effectiveness is tracked at all levels.

Outcomes for <u>adults</u> in FY 2005 in RDM are:

- 78% with improved or stabilized functioning
- 88% with improved or stabilized risk of harm
- 82% with improved or stabilized housing

- 86% with improved or stabilized employment
- 91% with improved or stabilized criminal justice involvement
- 97% of adults avoided spending time in crisis (i.e., avoided being placed in 23-hour observation in a hospital setting, crisis counseling, etc.)

Outcomes for children in FY 2005 in RDM are:

- 80% with improved or stabilized functioning
- 92% with improved or stabilized risk of harm
- 92% with improved or stabilized school behavior
- 84% with improved or stabilized severe aggressive behavior
- 89% who avoided re-arrest
- 98% of children avoided spending time in crisis (i.e., avoided being placed in 23-hour observation in a hospital setting, crisis counseling, etc.) [44]

In addition, a study conducted by Heath and Human Services Commission, Strategic Decision Support, shows the FY 2005 average monthly ER cost among Medicaid clients receiving RDM services was $68 vs. $98 among Medicaid clients not receiving RDM services, which amounts to an average savings of $25 per Medicaid client per month. **Texas' average monthly hospital ER costs for FY 2005 were 27% lower for Medicaid clients receiving DSHS RDM services.** [45]

Jail Diversion strategies were implemented across all 254 counties in Texas in response to the growing incidence of mental illness within the criminal justice system. In order to link offenders with mental illnesses to mental health services, some community centers have established positive relationships with jails, law enforcement, and the judiciary. Centers have inserted mental health professionals early in the criminal justice process in order to divert to treatment of non-violent mentally-ill offenders, and ensure mental health services are available in jail. [46]

For instance, the MHMRA of Harris County provides a range of services, including initial screening to determine if an inmate has a mental illness, and provide treatment and services in a segregated unit of the jail for persons who need more intensive psychiatric and support care. Because of the MHMRA center's competency restoration services in the jail, Harris County is no longer responsible for transporting individuals deemed incompetent to and from the local state hospital.[47]

According to the Mental Health Association of Texas, people with mental illness tend to serve longer prison sentences and recidivate at a higher rate than other inmates.

- 79% of local jail inmates with mental illness had prior criminal convictions compared to 71.6% of other inmates.
- The cost to Texas for 'revolving door offenders' is an estimated $682 million per year as compared to $92 million for treatment in a community mental health center; and
- Roughly 16-18% of people suffering from mental health issues are in Texas jails.

Interim results for Bexar County Jail Diversion Project during FY 2004 (sent by Gilbert Gonzales, Center for Healthcare Services, 04/26/06 to DSHS) showed an estimated range of

$3.8 million to $5 million in avoided costs within the Bexar County Criminal Justice System.

- **3,764 persons suffering from mental illness were diverted from inappropriate incarceration from September 2004 to March 2006.**
- **Law enforcement man hours saved (on 7 month averages) were equivalent to $42,192.50 for San Antonio Police Department and $2,442.50 for Bexar County Sheriff's Office.**
- **Wait times for law enforcement accompanying a person needing medical and mental health screenings were nine hours or more before implementation of their jail diversion project. Now wait times are as little as 45 minutes.** [48]

Changes made by implementing the jail diversion strategies are intended to reduce the cost to government through reduced involvement in the criminal justice system, and in the end, effectively improving the health of those affected by mental illness.

In March 2006, the National Alliance on Mental Health (NAMI) published its report card, grading each state's mental health system. The state mental health systems were analyzed in four categories: infrastructure, information, access, services, and recovery.

The Nation received a "D" overall; 5 states received a "B"; 17 states received a "C"; 19 states received a "D"; 8 states received an "F"; and 2 did not complete the survey. Texas received a "C" overall and a "B" for services; a great accomplishment for a state that ranks 47th in per capita funding for mental health services and still only in its second year of implementation of the RDM model. [49] Thus, Texas' performance indicates that funding should not be the sole measurement of system achievement.

Funding Mechanisms for Behavioral Health:

Unit Rate (Fee-for-service): This payment mechanism is used for substance abuse treatment services that are reimbursed at a set rate per unit of service for treatment (outpatient) and multiple residential services. Contractors report the service units delivered during the previous billing period through claims and are required to submit data reports on clients served in the program who are supported by DSHS funds. Claims and data reports are submitted through the BHIPS, an internet-based electronic system that supports a comprehensive service delivery system. Reporting requirements are specified in the contract.[50]

Cost reimbursement: This payment mechanism is used for prevention and intervention services in which funds are provided to carry out approved activities based on an approved statement of work and itemized budget. Amounts expended are billed on a monthly basis. Contractors are required to submit monthly performance information and financial reports. They are required to submit data reports on participants served in the program who are supported by DSHS funds. Monthly performance information and financial reports are submitted through BHIPS. Reporting requirements are specified in the contract.[51]

Community Mental Health Centers: Federal funds are distributed quarterly at the end of each quarter. All other funds are distributed as follows: 30% at the commencement of the first and

second quarters, and 20% at the commencement of the third and fourth quarters.[52]

Funding Equity for Mental Health services was mandated in the 2006-07 General Appropriations Act (Article II, Special Provisions, Sec 29, 79th Regular Legislative Session, 2005), requiring DSHS to implement a long term plan to achieve equity in state funding allocations among local mental health authorities. The equity plan is to be implemented from fiscal years 2006-2013 and equity should be achieved to the greatest extent possible by fiscal year 2013. It is also required that any funding reductions to a local authority for the purpose of achieving equity may not exceed 5% of allocated general revenue in a fiscal year. Improving funding equity is also a priority in distributing any new state revenue or federal funds that may become available for allocation to community centers. This is otherwise known as the "equity rider."

The Department of Aging and Disability Services (DADS) has designed its services to provide an effective and efficient funding mechanism for mental retardation services by maximizing the amount of non-state financial participation (Federal and other funds) in the Mental Retardation programs it manages and operates. Based on the chart below, less than 8 percent of all funds spent on Mental Retardation programs are not matched with federal funds.

Program	Enrollments	General Revenue	Federal	Other Funds	All Funds	% of Total MR Expenditures
Home and Community Based Services Waiver (HCS)	10,321	$ 155,674,186	$ 243,949,000	$ 2,987,600	$ 402,610,786	31.0%
Texas Home Living Waiver (TxHmL)	1,933	$ 3,991,660	$ 6,160,069		$ 10,151,729	0.8%
Community Center Services	10,116	$ 89,467,077	$ 1,341,049		$ 90,808,126	7.0%
In-Home and Family Support	2,674	$ 5,000,000			$ 5,000,000	0.4%
ICF/MR Residential Program	6,881	$ 129,912,784	$ 205,217,313	$ 3,932,996	$ 339,063,093	26.1%
State Schools	4,947	$ 172,172,284	$ 252,081,499	$ 26,850,108	$ 451,103,891	34.7%
Total	**36,872**	**$ 556,217,991**	**$ 708,748,930**	**$ 33,770,704**	**$ 1,298,737,625**	100.0%

Source: DADS Budget Status Report – March 2006

DADS established a workgroup composed of MR authority representatives, staff of the Texas Council of Community MHMR Centers, and DADS staff. Recommendations for implementing the equity rider were developed following two principles that support the philosophy of doing what is most logical and best for the consumers:

- the redistribution methodology should consider all accountable community resources; and
- the fundamental goal we should strive to achieve is that individuals with mental retardation and developmental disabilities should have equal access to services wherever they are in the state. [53]

At an average cost of $2,546 per individual (compared to $5,490 for 90 days in county jail and $5,400 for 10 days in an inpatient treatment facility), community-based services provide the most effective, efficient use of taxpayer dollars. -Mental Health Association of Greater Houston

The Texas Council of Community MHMR Centers reported that in FY 2005, centers more than doubled the impact of state general revenue dollars by securing nearly $45 million from local taxing authorities (primarily counties), nearly $70 million dollars in other local funds, such as grants and foundations, client fees, and third party insurance, nearly $250 million in earned Medicaid and Medicare, and around $150 million in other Federal and state funds. They also reported securing an estimated $55 million of free medications through the pharmaceutical companies to ensure medications for the mentally ill. Each year, an independent financial audit review is completed on the centers and distributed to all state agencies with whom the centers contract, as well as each sponsoring agency.[54]

With mechanisms in place and a sound equity disbursement plan, stabilization and additional allocation of funds in the mental health system are crucial to ongoing strategies like jail diversion and RDM.

Identify and study best practices in crisis intervention, residential treatment and aftercare.

Many times, individuals living with a mental illness in communities, who do not receive ongoing care, will experience a crisis. The patient can approach the crisis one of three ways: enter into a short term intensive, and many times expensive, treatment in an inpatient facility, access community-based crisis services, or admit themselves into a hospital emergency room, simply tempering the problem, not resolving it, and creating a vicious cycle.

Many have suggested an expansion on a comprehensive system of mental health services that will reduce the need for more restrictive and expensive levels of care, and use of overtaxed emergency rooms and unnecessary incarceration. Solutions point in the direction of a community based crisis intervention system.

The Department of State Health Services and its Crises Redesign Committee conducted regional hearings throughout the month of February 2006 in Austin, San Antonio, Harlingen and Big Spring and developed recommendations for a comprehensive array of crisis services.

The hearings were an opportunity for elected officials, social service providers, law enforcement agencies, and citizens to share their experiences, opinions, and recommendations regarding local psychiatric emergency services. The Committee heard testimony covering a range of issues, including access to crisis services, hotline services, and interface between local mental health authorities, emergency personnel, and hospital emergency rooms.

Testimony often revealed difficulty accessing emergency services, lack of consumer/family focus on care, and resource issues such as crisis beds and transportation services.

Throughout the hearing, several key themes emerged, including:

- The need for an evidence-based, standardized, clinical model for crisis mental health services
- The need for local collaboration and resource pooling between the county, city, local mental health authorities, courts, law enforcement, healthcare systems, and school districts

- The need to address rural crisis care issues, especially access to emergency services and competent providers; and transportation issues, including distance, cost, and availability
- The need for financial resources to develop a responsive community safety net
- The need for local crisis services for children and their families; the travel required to access non-local options and the lack of children's specialty providers were described as common barriers to treatment[55]

An example of a feasible and innovative local crises stabilization facility is the Tri-County MHMR Services project, covering Montgomery, Liberty, and Walker Counties. Beginning as a Block Grant project, the facility had broad based support throughout the counties, and eventually entered into a contract with the local hospital district, as well as receiving funding from DSHS. The project is a local, state, and federal partnership and has been a success in crises management services and an effective response system.

Also, in an effort reduce the overflow in jails, a select number of counties have opted into a deputy transfer program. The program helps divert mental health patients, often charged with misdemeanors like disrupting the public, or a comparable charge, from a local jail to a local medical facility for medical screening. After receiving medical clearance, Mental Health Deputies will be called to transport the inmate to a proper facility for mental health services. This step is potentially avoided by placing Mental Health Units in the field to divert MH patients from the criminal justice system altogether and connecting them with the appropriate mental health services. For instance, the Ector County Sheriffs Department has a group of specially trained officers who respond to persons in a mental health crisis. These officers are licensed peace officers, who have successfully completed a recommended Mental Health Certification course. They are thoroughly trained how to approach someone in a crises situation, and evaluate the need for medical care or immediate mental health services.

Currently, the Texas Department of Criminal Justice (TDCJ) and Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) fund transfer programs in Odessa and San Angelo. Many times, when the funding cycle ends, counties choose to take the initiative over due to the success of the program. For instance, Galveston has seen 25 years of success in its own county-funded transfer program. [56] Although counties have the choice to opt into this program, they do realize it is funded solely by the county. However, positive outcomes directly affect the county itself, so cost may be justified. It is not known at this time what the cost benefit would be to the state if any, but because of the initial success from select counties, further studies should be conducted to evaluate the deputy transfer program. For example, the study should further examine what percentage of mental health patients transferred were jailed because of misdemeanors and/or what percentage were jailed because of felony charges. These specifics will help counties and the state identify how long mental health patients remain in the system and at what cost to the state.

Data collected on Best Practices in crises intervention:

Assertive Community Treatment – An ACT team is a comprehensive, multi-disciplinary mobile outreach team serving adults with severe and persistent mental illness. The primary goal of the ACT team is to improve the quality of clients' lives and the lives of their families, and to

decrease or eliminate the client's need for crisis services. Only clients with the highest need for assistance are admitted into ACT. Of 25 studies conducted on ACT in the past two decades, 74% found that it was positively correlated to a significant decrease in psychiatric hospitalization, 67% showed an improvement in housing stability, and 57% demonstrated an overall improvement in consumers' quality of life. [57] Today in Texas, DSHS has approximately 50 teams in operation throughout the state in both rural and urban areas. Based on national figures, the cost range for ACT per person per year is $8,125 to $11,500. Costs differ around the state based on cost of living and salaries.

Supported Employment – Individuals sometimes need assistance getting and keeping a job in the community. Supported Employment staff work with clients to determine their work goals and assist them through the application, interviewing, and on the job skills development process. Staff also work with businesses in the community to open the doors of opportunity that are often shut to clients. It is important to help the customer feel in control of the process. [58] DSHS currently uses the supported employment program as best practice.

Supported Housing – Finding affordable housing can be difficult for clients. Staff works with clients to find suitable housing and furniture so the client can live and work in his or her community. A comprehensive study of the supportive housing program in New York City tracked 4,679 individuals and found that:

- emergency shelter use decreased by 85% from an average of 68.5 days/year to less than 10 days/year.
- state psychiatric inpatient utilization dropped by 60% from an average of 28.6 days/year to less than 12 days/year.
- incarceration in state prisons and city jails dropped by 74% and 40% respectively.
- the use of outpatient services almost doubled by an average of 31.1 days a year to 60.8 days a year.[59]

DSHS oversees the **PATH (Projects for Assistance in Transition from Homelessness)** program, authorized under Sec. 521 (290cc-21) of the Public Health Service Act. Funds are distributed on a formula basis by the Federal Center for Mental Health Services.

Services to be Supported by PATH
Outreach; screening, diagnostic assessment and treatment; habitation and rehabilitation; community mental health services; outpatient alcohol or drug treatment (for clients with serious mental illness); staff training; case management; referrals for primary health services, job training, educational services (including HIV prevention activities), and relevant housing services; assistance in obtaining income support services including Supplemental Security Income (SSI) and representative payee per appropriate regulations. Housing services offered, including planning for housing; technical assistance in applying for housing assistance; and improving coordination of housing and services and the costs of matching individuals with appropriate housing and services.[60]

(Although these programs can also be utilized in aftercare, they serve as preventative methods to crises)

Residential treatment and aftercare

As noted previously, the only DSHS-run psychiatric residential treatment facility is the Waco Center for Youth (WCY). WCY serves teen-agers, ages 13 through 17, with emotional difficulties and/or behavioral problems. WCY bases its treatment philosophy on the belief that both behavior change and an understanding of self and others are equally important in achieving significant long-term success in treatment. The mission of WCY is "to give each youth a chance for change" by providing comprehensive psychiatric residential treatment services to emotionally disturbed adolescents. [61]

Best practices for WCY include:

Comprehensive Campus Behavior System – Is intended to shorten, simplify, and improve positive reinforcement; eliminate the use of "fines," and reduce unnecessary power struggles between direct care staff and residents; Automate records and data collection to minimize human error; Monitor progress and target specific behaviors and graph behavioral data over the course of treatment. The CBS is designed to teach and coach adolescents in improving in five behavioral areas; the acronym SPARK is used as the primary guide to positive behavioral change and each adolescent is given scores by the facilitators of each activity based on success in the five areas throughout the day. Staff are trained to look for opportunities to provide positive reinforcement by recognizing and acknowledging the positive behaviors exhibited by the adolescents no matter how small. The expectation is that staff will coach them on ways to achieve higher scores that will result in movement up the level system and increased privileges.

***S** – Stay Healthy – nutrition, hygiene, medication compliance, exercise, sleep, etc.*
***P** – Participate Actively – attends and participates in scheduled activities.*
***A** – Avoid High Risk Behaviors – examples are runaway behavior, taking illegal drugs, aggressive behavior, self injurious behavior, etc.*
***R** – Remember Instructions – pay attention to and comply with instructions that are part of every activity and setting on the campus.*
***K** – Kindness and Respect – treat peers, staff, and visitors in a way that reflects positive interpersonal interactions.*

Behavioral Management Risk Reduction Efforts – In order to reduce personal holds, mechanical restraints, and seclusion, STARS (Staff Training About Restraint and Seclusion) training was implemented, which was developed and taught by WCY's Chief Nurse Executive, Director of Quality Management, Risk Manager, and Safety Officer. WCY attempted to encourage corporate ownership and responsibility to reduce and/or eliminate behavioral interventions. Previous to this effort, activities related to behavioral interventions have fallen solely on the clinical component of the facility. The paradigm shift has been accomplished to include all employees at the facility. For example, all WCY employees have been trained as third party observers. Also, an example of a "best practice within a best practice" was the facility's implementation of the 911 Psychiatric Emergency Group Page procedures. It is WCY's model of "all hands on deck" when there is a behavioral crisis anywhere on campus.[62]

Both models appear to be based on a behavioral reconciliation approach, and perhaps work best on

children. It is uncertain how duplicate models would work with adults in the same environment in Texas, but positive reinforcement and behavioral management, rather than restraint methods of treatment, appears to be a better approach.

DSHS has also provided *ongoing* care through the Access to Recovery (ATR) program, which supports clients by offering needed treatment or recovery support services to successfully complete their drug court program. Drug courts offer a cost-effective alternative to incarceration by providing a community-based treatment as a condition of probation. Cost effectiveness of the ATR drug court program in Texas is shown in the following outcomes:
-92% remain abstinent
-59% remain employed or in school
-91% have no further arrests
-99% are not homeless
-87% are socially connected

There are currently 55 drug courts in Texas, dealing with pre-adjudication, post-adjudication, mental health.

Psychosocial Rehabilitation is another transitional link into aftercare.

Psychosocial rehabilitation is the name for a combination of services that are designed to help a person living with a mental illness live independently. These services may involve housing, employment or social supports. This form of treatment can help them acquire or regain the practical skills they need to live their life while coping with the symptoms of the illness. Social and work skills are learned, helping them relate to other people, while boosting their confidence. Living skills, such as proper nutrition, personal hygiene, cooking, shopping, budgeting, housekeeping, and using public transportation are also acquired. It is left optional as far as what services are important to each person and a case manager or mental health professional works to help arrange those services.[63]

Aftercare can be an advantageous experience for MHMR patients, leading them through recovery by offering peer to peer support activities and employment opportunities. Currently, though, 75-85% of the mental ill population is unemployed, which leads to a revolving door for treatment.[64] Encouraging independence through home ownership and steady employment creates a healthy environment for the individual, making a crisis less likely to occur or reoccur.

(Long-term/ongoing services care)
The Department of Aging and Disability Services, along with members in the mental health profession across the state, united to come up with a service delivery model, benefiting the elderly and those with disabilities living in communities.

"Older Texans and persons with disabilities will be supported by a comprehensive and cost-effective services delivery system that promotes and enhances individual well-being, dignity, and choice" - DADS vision statement

DADS centered the service delivery system design plan on self-determination.

Self-Determination

- Consumer Directed Services (CDS), a component of self-determination, allows for:
  - Increased control over services and supports
  - Increased control over the persons that provide services and supports
  - Informed-choice for decision making
  - Understanding the risks and benefits of decisions

As part of CDS, DADS created the,

Money Follows the Person Initiative:

- Money Follows the Person (MFP) allows Medicaid clients in Texas' nursing facilities to receive services in their community as long as the cost does not exceed the institutional cost for services.
  - H.B. 1867, 79th Legislature, Regular Session, 2005, codified the MFP option previously authorized by rider.
- Texas' Money Follows the Person initiative was awarded first-place honors at the Council of State Governments, Southern Legislative Conference, 2006 Innovation Awards Competition.
- Since September 1, 2001, approximately 11,300 residents have utilized the Texas MFP provision.
- A critical component of MFP is contracted relocations specialists. DADS currently has four contracts for $1,227,488.
- HHSC Promoting Independence funds will increase the funding for relocation activities by $606,744 beginning in FY07.
  - This additional funding will permit DADS to increase the number of people served and decrease the size of the contract service areas.

The federal Deficit Reduction Act (DRA) includes an opportunity for DADS to expand the MFP initiative.

- Under the DRA – MFP grant, any Medicaid-eligible individual who has resided in a nursing facility, **hospital, or ICF/MR** for a specified period of time depending on state policy (at least 6 months up to 2 years) would be eligible for MFP.
- CMS would pay an enhanced rate for 12 months for qualifying individuals who choose to receive services in the community.
- For Texas, the enhanced rate would result in an increase in the federal match from 60 percent to 80 percent of eligible client costs for one year.

DADS intends to submit a grant application in order to provide more services in community settings at an increased Medicaid match.[65]

Identify and study successful mental health services delivery models established by other states.

The South Florida State Hospital, fully privatized under GEO Care, Inc. on November 1, 1998, implemented the Psychiatric Rehabilitation Model. This model is a base for providing services to

people with mental illness that encourages adaptive community functioning. The philosophical base of psychiatric rehabilitation is built around the principles of empowerment, competence, and recovery.[66] The previous model was devoted mostly to custodial care, with no hospital accreditation and a service area of only 35%. Prior to privatization, the State Hospital also dealt with an ongoing major class-action lawsuit concerning patient abuse and poor conditions. The current condition of the South Florida State Hospital, under privatization, received JCAHO accreditation within 10 months of the new partnership, increased its service area to 54%; reduced the average length of stay; experienced a low recidivism rate; enacted active individualized patient treatment plans; and made a dramatic reduction in restraint and seclusion -- all resulting in the dismissal of the class-action lawsuit.[67]

Restraints and seclusions were reduced from an excess of 16 per month to **less than 1** per month in the new system. Length of stay in the hospital was significantly reduced from 8 years to less than 1 year, and a waiting list, which existed prior to the new system, was eliminated, resulting in higher number of persons served. Other reported outcomes:

- new facility built at no additional cost to taxpayers
- "best practices" programs recognized by JCAHO
- successful community transition through aftercare services, including psychosocial support and medications
- current cost lower than all other state facilities
- fostered innovation and competition among existing facilities[68]

The privatization of the South Florida State Hospital has been backed by the National Alliance for the Mentally Ill and the Mental Health Association, as well as the Florida Statewide Advocacy Council, who stated in a letter to Governor Jeb Bush, "The Council has found that the treatment philosophy and approach have been enhanced by the implementation of the psychiatric rehabilitation model. Under privatization, GEO Care Inc./South Florida State Hospital received JCAHO accreditation for the first time in its history and remains the only accredited state civil hospital. [We] support the privatization of additional state facilities in Florida and recently, unanimously passed a motion to that effect."

Department of State Health Services noted in their presentation to the Committee on Human Services in May, several states with services delivery models that have a different approach:

- Ohio & California: County-based service system with county taxing authority
- Arizona: Regional behavioral health authorities; managed care system
- New Mexico: Single purchasing model
- Pennsylvania: County-based, capitates managed care model
- Illinois & New York: Direct state contracts with provider network

Kansas has a model similar to Texas (in the Comprehensive Campus Behavior System and Behavior Management Risk Reduction models used at the Waco Center for Youth), but uses strength-based treatment models,[69] instead of the "best practice" approach.

CONCLUSION:

Where do the answers lie for mental health improvements in Texas?

It is worth noting again that although Texas ranks 47th in funding per capita, the state still achieved somewhat high marks regarding its new implementation of the resiliency and disease management strategy and jail diversion programs mandated across the state. Already nationally recognized, the state is on line for continuing effective mental health services, and has great potential with enhancement in the successful RDM model.

DSHS continues to plan for long-term, community-based solutions to address the hospital capacity issue, as the beds per patient ratio is still a priority problem to date.

DSHS overarching goal is to improve the mental health of all Texans and meet the President's New Freedom Commission goals, including ensuring consumer-driven services, elimination of disparities, and using technology tools to increase access to mental health care.

As demand for mental health and substance abuse services continues, DSHS' focus is on:

- Making the most out of cross-agency partnerships
- Making better use of information technology and evidence-based practices
- Keeping individuals out of crisis
- Reducing demand for hospital services
- Maintaining quality hospital services
- Analyzing the impact of behavioral health issues on other systems [70]

An evidenced-based crisis services redesign model, made a priority by DSHS, will increase access to necessary and cost-effective services. As emergency rooms and jails become overburdened everyday with psychiatric patients, crisis intervention in Texas no longer is just an approach to patient care, but a solution.

The Department of Aging and Disability Services and Department of State Health Services both provide a public health safety-net of services to the most vulnerable people in Texas, and in order to continue to do so, maintaining sufficient funding is crucial. DADS recently stated that "Demographic projections indicate that the demand for DADS programs will continue to grow. It is imperative that the infrastructure, which provides the foundation for these programs, keeps pace with program growth in order to ensure the safety and well being of people receiving our services." [71]

With programs like Resiliency Disease Management and Jail Diversion strategies, as well as increased accessibility and improvements to crises services, Texas is on the fast track to addressing the needs of persons affected by the mental health system.

CHARGE #3:

Monitor how changes in the Food Stamp Program at the federal level affect participation in Texas, including proposed changes in the 2006 Federal Farm Bill.

BACKGROUND:

The U.S. House of Representatives, Committee on Agriculture, has only just finalized hearings on testimony regarding recommended changes to the 2002 Federal Farm Bill and will take the information gathered from the hearings as they begin the farm bill debate in early 2007. At this time no changes to the farm bill have gone into effect, so the Committee on Human Services, with the assistance of the Texas Health and Human Services Commission, can only suggest what impact the President's current proposed changes will have on the Food Stamp Program in Texas.

Food Stamp Proposed Changes:

According to the HHSC, the President has proposed the following for the 2007 budget:

- ***Exclusion of retirement accounts***
- ***Eliminating categorical eligibility for TANF Non-cash Households***
- ***National Directory of New Hires database access***
- ***Transition former Commodity Supplemental Food Program recipients into the Food Stamp Program***

Exclusion of retirement accounts-
Current policy:
Individual Retirement Accounts, Simplified Employee Pension plans, and Keough plans are all countable resources when determining eligibility for Food Stamps. All other retirement accounts and plans are excluded as a resource for determination.
Proposed policy:
To exclude all tax-favored retirement accounts when determining eligibility.
Impact:
This will create increased access to the Food Stamp program for the elderly. Staff would no longer need to verify and determine the value and balance of retirement accounts, therefore reducing workload. BUT this would require systems changes, training and policy handbook revision. [72]

Elimination of Categorical Eligibility-
Current policy:
Households receiving TANF cash assistance, Supplemental Security Income (SSI), and TANF non-cash assistance are categorically eligible for Food Stamps. In Texas, all of these households are considered eligible except those in which a member is disqualified due to an intentional program violation.

The eligibility criteria for TANF non-cash benefits (which includes services for family planning, adult education, prevention and treatment of substance abuse, employment services, domestic violence, and Women's, Infants and Children nutrition - WIC), must meet the following:
-combined liquid assets and excess vehicle value total $5000 or less
-gross income is below 165% of the federal poverty level (FPL) for household size
-if income limit is met, household is not subject to gross/income test
-remaining resources are exempt

Proposed policy for categorical eligibility:

Only households receiving cash assistance, TANF or SSI, would be categorically eligible for Food Stamps. Households that were previously eligible for TANF non-cash benefits would not be categorically eligible, and would now be subject to:
-gross/net income limit
-$2000/$3000 resource limit; and
-vehicle exclusion of $4,650 of fair market value of the first countable vehicle.

Impact:

Two percent (18,000-20,000 cases) of the Food Stamp caseload has income over 130% FPL, which is the limit food stamp regulations establish for households that are not categorically eligible. (see chart below for Poverty Level guidelines)

HHSC does not have data to accurately estimate the number of households that would be affected by a lower resource limit, but reported that it is possible that several thousand working families may be ineligible due to excess assets, including many families who own a vehicle values over $6,650.

Additional impacts reported by HHSC are an annual loss of over $14.4 million in Food Stamp benefits to families whose benefits will be denied. An economic impact, generated by federal dollars is expected, as well as increased staff workload in order to verify equity value of countable resources that is currently excluded. Systems changes and training implementation for workers, as increased quality control will be necessary with additional verification requirements and added complexity. [73]

2006 HHS Poverty Guidelines

SOURCE: *Federal Register*, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 9,800	$12,250	$11,270
2	13,200	16,500	15,180
3	16,600	20,750	19,090
4	20,000	25,000	23,000
5	23,400	29,250	26,910
6	26,800	33,500	30,820
7	30,200	37,750	34,730
8	33,600	42,000	38,640
For each additional person, add	3,400	4,250	3,910

National Directory of New Hires-

Proposal:
Gives states the option to access the National Directory of New Hires data base for food stamp applicants and recipients to match employment and wage information.

Texas Match Process:

Employers by law must report newly hired and rehired employees to the Office of the Attorney General (OAG). The OAG maintains this information and sends HHSC a weekly electronic file to match with system data. The match creates the Employer New Hire Report (ENHR), which is then distributed to HHSC staff for clearance.

ENHR is produced for Food Stamp streamlined reporting households if gross income is within $900 of the 130% FPL and the household member on the ENHR file has gross earnings less than $900. Streamlined reporting households with income about 130% FPL are not required to report changes in income.

Impact:
Staff workload would again be increased due to the need to verify information generated from the nationwide match of employers, also assuming increased quality control and systems changes. [74]

Eliminating Commodity Supplemental Food Program-
Current program:
The Commodity Supplemental Food Program (CSFP) provides food packages to about 450,000 persons nationwide per month, primarily to those 60 and over, but also to low-income pregnant and post-partum women, infants, and children up to age 6 (not receiving WIC).
Proposal:
CSFP is apparently no longer needed because current recipients qualify for other programs, like Food Stamps and WIC. The elderly are the only group that can participate in CSFP and Food Stamps concurrently. Current recipients age 60 and over would be eligible to receive food stamps equal to $20 per month for up to 6 months, until they are determined eligible for the regular Food Stamp Program.

Texas CSFP operates in Dallas, Webb, and Zapata counties, accounting for 12,378 recipients, 11,759 of which are age 60 and older.

Impact:
The impact on Texas is unknown because the budget does not address how the transitional food stamp benefits would be issued to the eligible individuals.[75]

Integrated Eligibility and Food Stamp Program access is discussed at length in the next section overview on Interim Charge 4.

CHARGE #4:

Monitor the agencies and programs under the committee's jurisdiction.

BACKGROUND:

Representatives of the following agencies, whom the Committee oversees, were called to testify in an interim hearing by the members of this Committee, on current and future program initiatives within their agency.

- Texas Heath and Human Services Commission (HHSC)
- Department of Family and Protective Services (DFPS)
- Department of Aging and Disability Services (DADS)
- Department of Assistive and Rehabilitative Services (DARS)

Texas Heath and Human Services Commission (HHSC)-

HHSC's Current Initiatives are:
- Integrated Eligibility and Enrollment (IEE)
- Comprehensive Healthcare for Foster Children
- Use of Psychoactive Medications In Texas Foster Children

Probably the most discussed, because of glaring initial challenges, but still carrying great potential, is the Integrated Eligibility and Enrollment (IEE) system.

HHSC holds the responsibility in determining eligibility for state services, which includes the Children's Health Insurance Program (CHIP), Medicaid, Food Stamps, Temporary Assistance for Needy Families (TANF), and long-term, financial, care for the elderly and people with disabilities. (1043 additional staff were most recently deployed in both Texas Works -- Food Stamps, TANF, and Medicaid -- and Long Term Care Medicaid Financial Eligibility Determination.)

HHSC found that there was a "clear and compelling" need to modernize the eligibly system, in order to expeditiously and effectively determine eligibility to this massive population. The model currently in place to perform demanding functions, is a very outdated service delivery system. Designed in the 1970s, the delivery system is difficult to maintain and update, and cannot easily respond to workload changes, consumer preferences, or other external factors.[76] A survey of clients was taken by HHSC that supported the desire for change in the current eligibility system:

- 80 percent said they would be likely to use the phone to apply for services.
- 36 percent said they would be interested in applying online.
- 28 percent rely on public transportation or someone else to take them to an office.
- 82 percent wanted to be able to apply outside of normal work hours and not lose time on the job.
- 81 percent wanted to be able to apply in private "without others around."[77]

If kept in place, funding for the current eligibility system would also be exponentially higher, requiring increases in appropriations. HHSC reported that if the system staffed at the FY 2002 level, the current eligibility model would require more than 13,000 staff; an increase of 7,000 over current staffing levels. Staffing at this level would cost more than $250 million per year in all funds.

As a result of the 78th Legislature, 2003, HHSC was directed to establish call centers, if cost-effective and required to outsource call centers unless HHSC determined that contracting for the operation of the call centers would not be cost-effective. In order to carry-out the directives of the Legislature, HHSC completed an Integrated Eligibility Discovery report in November 2003, which examined the current system and defined the preliminary vision for IEE/call centers, and created the financial model to support future business decision-making. [78]

Results of the study of the new eligibility system, determined that the use of outsourced call centers, rather than state-operated, would be cost effective:

• The cost of state-operated call centers were projected to be 15%, or $436.4 million, less than baseline costs over a 5-year period.

• The cost of outsourced call centers were projected to be 22%, or $646.1 million less than baseline costs over a 5-year period.

HHSC's Goals for the New Eligibility System:
To create options for consumers -
• Client Can apply in person at over 200 offices
• Client Can apply by telephone, Internet, fax or mail
• Expand the use of technological tools and modern business processes
• Convert to electronic case files, which creates a more flexible model
• Cost-effective use of taxpayers' money

HHSC contracts with the Texas ACCESS Alliance, who maintains multiple responsibilities, including integrated eligibility services for Medicaid, Food Stamps, and TANF. HHSC and TAA have both realized the need for improvements in the 4 pilot areas, and will maintain accountability through:

<u>Key Performance Requirements</u>- includes timeliness and accuracy standards.
<u>Fixed and Variable Costs</u>- payment structure is NOT tied to eligibility determination outcome.
<u>Consequential and Liquidated Damages</u>- Vendor liable for sanctions imposed by federal agencies.

Although concerns have been evident in the new eligibility system, reductions have already taken place in just a two month period in the call abandonment rate at a TAA Integrated Eligibility Call Center:

Item	Total for Month of July	Total for Month of August	Rate of Reduction
Calls Abandoned	**2,627**	**447**	**94%**
Abandonment Rate (calls abandoned/calls queued)	**3.76%**	**0.61%**	**93%**[79]

As HHSC continues to monitor monthly TAA status reports and client feedback, system improvements and steady growth with be sustained.

Comprehensive Healthcare for Foster Children, as discussed previously in the report is an ongoing and extremely vital feat. Senate Bill 6, passed during the 79th Regular Session, directed HHSC to develop a new statewide model for children in foster care and made the operational state date September 1, 2007. Texas is the first state to implement a statewide model of this magnitude. The new model targets children and young adults in DFPS conservatorship, emancipated minors and young adults (ages 18-21), who voluntarily continue in a foster care placement, and young adults who have exited foster care and are participating in the foster care youth transitional Medicaid program. [80]

New Health Care Model goals are to:
• deliver integrated physical and Behavioral Health Services, centralize Service Coordination, and effectively manage health care data and information;
• provide the Target Population with a consistent source of health care through a Medical Home (a team consisting of caseworkers, physicians, and nurses, etc.); and
• improve health care outcomes through enhanced quality of services.

Specifically, program components will include expedited enrollment for immediate services though a coordinated care model. A medical home is expected to offer better preventive care and coordinated care through a Primary Care Provider (PCP) or PCP Team, and act as a single point of accountability for children. Improved access to health history and medical records will be achieved through a web-based Health Passport; helpful to both doctors and patients. A 7-day, 24-hour Nurse Hotline and Behavioral Health Hotline will be in place for caregivers and caseworks and medical advisory committees will monitor provider/network performance.

Many of the benefits listed above will be managed by an MCO, (managed care organization), who HHSC will contract with to ensure more accountability of children's care. Also included under the MCO's management are physical and behavioral health, a pharmacy, dental services, mental health rehabilitative services, which was not previously included, and attendant care for long-term service. [81]

Recapping the section on mental health for foster children: HHSC has studied the use of

Psychoactive medications in Texas Foster Children, and in February of 2005 distributed the Psychotropic Medication Utilization Parameters for Foster Children to all Medicaid providers.

The need for the parameters, were raised when a 2004 report by the Office of the Inspector General (OIG) raised concerns about the use of psychoactive medications in foster children. HHSC worked along with DFPS and DSHS to assess the problem and assist providers in more appropriately distributing these medications through detailed guidelines.

Subsequent to the release of the guidelines, prescribing trends for foster children decreased. Examined usage of psychoactive medications in foster children was based on a five month period before and after the release of the guidelines.

Utilization prior to the release of guidelines
•26% of foster children received a psychoactive medication for at least 60 days in SFY 2005.
•The use of psychoactive medications in foster children increases with age. (*Less than 1% under age 3 to 52% in ages 13-17.*)
•86 children (0.8%) under age 3 received psychoactive medications for a period of 60 days or longer in FY 2005
•396 of 37,052 foster children (1.1 percent) received 5 or more psychoactive medications at the same time.
•No children under age 4 received five or more medications at the same time.
•Older children more commonly suffer from BipoloarDisorder and Schizophrenia.

Changes in prescribing post guidelines

•Prescribing trends decreased in the 5 months following the release of the guidelines

•Percentage of children taking two or more psychotropic medications decreased by 28.7%

•Prescribing 5 or more medications at the same time decreased by 30.9%

•Prescribing to children without a mental health diagnosis decreased by 21.8%

HHSC is working to develop strategies to understand the clinical needs of the patients, in order to treat them clinically, rather than having to resort to medications. The agency is also working with prescribers to see if other treatment alternatives might assist in decreasing the number of psychoactive medications prescribed, as well as encouraging the vendor to work with providers to encourage appropriate prescribing methods.

***Future initiatives at HHSC*:**

It has already been established that modern technology assists clients in many ways, like increasing accessibility to HHSC programs and speeding up the application process for eligibility. Working to expand on the possibilities of technology, HHSC is looking at creating the Medicaid Access and Integrated Benefits Cards.

The Medicaid Access Card deals with client and Provider benefits and will make the check-in process for both much faster. It will be one permanent card, replacing monthly paper cards that the client had to maintain previously. There will be automated eligibility verification for all clients at point of service. The card will also ensure that services are rendered to the enrolled client. [82]

The Integrated Benefits Card will be one card for clients to access benefits from multiple state programs, like Medicaid, TANF, Food Stamps, and WIC. Combined access to these programs will visibly be a much easier process.

The Department of Family and Protective Services (DFPS)-

Program areas for DFPS are Adult Protective Services (APS), Child Care Licensing (CCL), Child Protective Services (CPS), and Purchased Client Services (PCS).

In order to accurately describe what initiatives DFPS is working on currently and down the road, it is best to summarize its responsibilities for each program area.

Adult Protective Services (APS)

- Responsible for investigating abuse, neglect, and exploitation of adults who are elderly or have disabilities
- Provides or arranges for client services as necessary
    - Financial, social, and health services
    - Referrals to other state and community resources

DFPS is currently improving the structure and practice of its APS program by completing 98% of the 252 HHSC Reform Recommendations.

Current initiatives:

Guardianship Program Transfer - The Guardianship program transfer to DADS from DFPS, eliminates conflict of interest, and increases safety and security for clients. A guardianship workgroup was formed, which included DFPS and DADS staff and ensures the coordination of policy between the two agencies and will address new issues as they arise over time.

Quality assurance and performance management has been attained by DFPS through the APS Performance Management System and quarterly performance reports to the Legislature.

The Performance Management system identifies key measures of program performance and establishes individual and program accountability for successful client outcomes:

- Employee performance standards developed for all APS employees.
- Comprehensive performance management reporting system devised to provide managers and caseworkers with timely performance updates.
- APS had submitted three quarterly performance management reports for FY 2006 to the Governor and Legislative leadership.
- Center for Program Coordination staff trained APS supervisors in each region on the new APS Performance Management System. APS supervisors now have daily reports available on-line to monitor caseloads and case quality.

DFPS also hired five case readers to measure case quality. The cases are read and scored using a standardized instrument. Scores are tabulated and reported to regional and state office management for consultation with local unit supervisors, managers and caseworkers.[83]

Complex cases are investigated by subject matter experts, employed in each region, in self-neglect and exploitation and evidence-driven inquiries. Supervisors are now responsible for reviewing recidivistic cases and assisting caseworkers with a long-term plan to resolve the issues that keeps clients in the system. CARE- client assessment and risk evaluation was developed as a risk assessment tool, which examines five areas of the client's circumstances: living conditions, financial status, physical/medical status, and social interaction and support. This tool may help to reduce the recidivism rate in APS though prevention.[84]

Staffing and caseload numbers have been an ongoing issue for DFPS. In order to address these issues, DFPS offers an education stipend to all APS workers, encouraging caseworkers to attain a higher level of education in APS-related fields and promotes workforce retention. A basic training curriculum is required, and includes web-based classroom, and on-the-job training, as well as expanded training from 3 to 11 weeks.

An technological answer to the efficient balance of multiple cases, for caseworkers who have to go out in the field many times daily and report back to the office, has been the Tablet PC, accompanied a by digital camera. The Tablet PC allows the caseworker to process the report of a visit with a client immediately, allowing them to move on to another visit. When returning to the office, the caseworker can make supplementary comments about each visit, but the reports are essentially finished and uploaded in the field. DFPS also received authorization from HHSC for additional direct delivery staff in order to meet growing caseload demands. [85]

Child Care Licensing (CCL)

- Responsible for protecting the health, safety, and well-being of children who attend or reside in regulated child care facilities and homes
  - Issues permits to allow regulated child care to operate
  - Provides consultation, technical assistance, and training for child care providers and educating the public in the selection and improvement of child care services
  - Develops minimum standards for regulated facilities and policies for enforcement of the standards

DFPS has hired and trained an additional 60 new residential licensing workers. Licensing regulations have been increased, as well as administrative penalties. For instance, DFPS increased the time frame a facility is prohibited from reapplying for a license, from two years to five years, after denial or revocation of a license. New provider requirements have been implemented, such as drug testing and new reporting provisions.

Inspections on both day care facilities and residential child care operations are performed routinely, and made public on the DFPS website. **Information on any facility or residential operation licensed in the state can be accessed fairly easily, by entering the DFPS website> http://www.dfps.state.tx.us/ >click on Child Care Licensing>click on Search Texas Child**

Care>click on either Search for a day care or Search for a residential operation>and enter the correct fields. The public is open to view background information like the date the operation's permit was issued, the number of inspections, how many violations were sited for the operation, and the date the violation was corrected; and so on. Issuing further answerability, DFPS began random sampling of foster and group homes as of January 1, 2006, with a total of 277 homes inspected.

Mandated background checks against the DFPS and Department of Public Safety (DPS) database are conducted
-- upon an individual's initial application for employment
-- upon a facility's application for license through the state
In residential facilities, background checks are done prior to employment or direct care of or direct access to a child. Results must be obtained within two working days or the facility may obtain direct information from DPS; DFPS still must verify by doing its own check.

The Licensing Division conducted 201,759 Texas criminal background checks of persons who are regularly or frequently present in child care operations in FY 2005. Those persons include child care licensing directors; administrators; owners and staff; anyone 14 years or older, other than clients, who is regularly or frequently present in a child care facility or family home while children are in care; applicants for a child care administrator or child placing agency administrator license; and applicants for adoption or foster parents.

CCL repeats the background checks on these individuals every 24 months.

FBI checks are done only if the person required to have a check is currently living in another state or if DFPS suspects a criminal history in another state. Federal background checks are difficult to run at the same frequency as state checks, due to the cost of each check; at around $40 per person.[86]

After a child death occurred in a Dallas child care facility, DFPS has added the following licensing changes to be implemented immediately:

- New directors will be required to show photo identification to licensing supervisors. This means the supervisors must meet with directors.
  (Previously, the state had said this was not required.)
- The department will retrain all licensing employees about director qualifications.
- All licensing employees will receive additional training about the minimum standards day cares must meet.
- Employees will be trained to better detect deception, making sure each facility is being truthful about the employment of staff and directors.

Protective services is also talking with the Department of Public Safety to set up a procedure to systematically cross-check the addresses of daycares with the addresses of registered sex offenders.[87]

The regulation of child care facilities and child-placing agencies routinely presents two challenges for licensing staff and permit holders:

1. consistency in interpretation of minimum standards; and
2. consistency in enforcement decisions and actions.

In an effort to address these challenges, CCL began developing a regulatory weighting system. Texas will be one of a few states in the nation using a type of weighting system in making regulatory decisions applicable to child care operations. A regulatory weighting system assigns a weight or categorizes individual minimum standard regulations, based on the risk to children. Prior to developing the weighted system, it was necessary to complete the revision of the minimum standards for residential child care operations and child placing agencies so that the weights will apply to the most current version of the standards. Workgroups of experienced staff and providers will participate in assigning the preliminary weights. A statistical analysis by Texas State University (in contract with DSHS), will be done using historical data for child day care operations and information from the workgroups of experienced staff and providers.

Project Status and Timeline:

- Complete interagency agreement with Texas State University to develop and determine preliminary weights. Status: Completed.
- Establish interagency workgroup to review and assign preliminary weights.
  Status: In process. The workgroup has been formed and is in the process of assigning preliminary weights.
- Texas State University prepares final report detailing the process used to identify the preliminary weights and support preliminary corresponding enforcement actions. Status: Due December 31, 2006.
- Through a second contract in 2007/2008, the preliminary weights assigned will be tested for validity and reliability. Adjustments to the weights will be made based on the findings resulting from testing, with the goal of implementing a new Licensing enforcement system.
  Status: Due 2007 through 2008.
- Validate the preliminary weights with the goal of implementing a new Licensing enforcement system. Due January 2008.[88]

The revised minimum standards have been approved and signed by Commissioner Hawkins at HHSC, and will be in effect January 2007. In order to assist providers in becoming familiar with the new standards, each provider will be given a copy of the standards in October, and DFPS is currently working with internal and external stakeholders on plans to implement the revised standards; including a plan for delivering training to the provider community.

Child Protective Services (CPS)

- Responsible for investigating reports of abuse and neglect of children
- Provides services to children and families
  - Transition services to youth aging out of foster care
  - Places children needing care in kinship, foster, and adoptive homes

Many changes were made to the CPS system, involving investigations, caseloads, caseworker

training, and community awareness.

DFPS created a new investigations structure, and fully staffed an Office of Investigations, including a CPS Director of Investigations. Of those hired, were 137 Special Investigators statewide, and 48 training staff who were schooled specifically for caseworker assignments and went through 12 weeks of basic training (up from the previous six-week training in place). Also hired were 7 of 11 regional law enforcement liaisons. These Regional law enforcement liaisons are specialized staff, whose primary function is to improve CPS' relationship with local law enforcement agencies and increase the quality and number of joint investigations.[89]

Additionally, 43 child safety specialists were hired for field offices. CPS caseworker staff that completed Basic Skills Development training before September 2005, were allowed to receive a newly developed Risk and Safety Assessment Training for five months.

Cases are being scrutinized by screeners (41 screeners hired to date), who have reviewed over 24,000 reports of child abuse and neglect as of June 30, 2006. Nearly one quarter of those cases have been able to be closed by CPS screeners.[90]

To ensure quality in investigations and protect children, DFPS has implemented a policy on audio and video taping children during investigations and in transporting of children from schools. CPS caseworkers will also be provided with a Tablet PC.

DFPS hired over 2000 new direct delivery staff since September 2005 and identified training needs for existing staff, and implemented a plan for training CPS direct delivery staff in new CPS reform initiatives and practice changes.[91] The Legislative Budget Board, also recently approved 100 conservatorship workers.

Administrative support staff and casework assistants were reinstated in order to handle more routine tasks and free up caseworker and supervisor time to focus on child safety and protection issues. This will help DFPS achieve their goal of reducing the average daily caseloads, from 44 daily, to 33 daily.

DFPS will contract with private entities to provide substitute care and case management services statewide by September 1, 2011.

It was the agency's intention to outsource with an Independent Administrator for Region 8; making it the first region to be outsourced. Estimated completion for transition of services in Region 8 was set for December 2007, with second and third regions to follow, completing the transition of services statewide by September 2011.[92] However, because of complicating factors and a breakdown in consensus with the leaders of Region 8, The Department of Family and Protective Services has decided to indefinitely delay issuing a tentative award for Independent Administrator Services for Region 8. DFPS will, in accordance with the requirements of Senate Bill 6, directly contract with case management and substitute care service providers instead.

In regard to the foster care system and family, DFPS has been working to make sure that children are placed with relatives before being placed in foster care. Family Group

Decision-Making (FGDM) was expanded with 2,370 FGDM conferences conducted, resulting in an increase in Kinship Care placements. To help family members serving as kinship caregivers, DFPS released a Kinship Care Manual. Preparation for Adult Living (PAL) provides Circle of Support for youth age 16 and older, and rules are currently being implemented to provide care for certain youth up to age 22. As discussed earlier, DFPS has worked on the expansion of transition centers and services for youth preparing for independence.

Effective September 2005, Medical Consent for each child in DFPS conservatorship is required. A court authorization of the medical consenter is required for each child in conservatorship, as well as training on informed consent and participation in each medical appointment by the authorized consenter. Sixteen and seventeen year old youth must be informed of their rights to determine their own medical care. The provision that birth parents must be notified of significant medical conditions is among the new requirements. In response to these new changes, DFPS offers medical consent training online for youth, staff, and consenters, and has hired regional nurses to provide medical consultation.

Community engagement is a very important partnership for DFPS in coordinating public awareness about CPS. As such, community engagement staff is located in each region to carry-out activities promoting community-based involvement. Currently there are 3,729 CPS active volunteers.

Purchased Client Services (PCS)

- Contracts with other entities to provide clients with needed services
- Manages prevention and early intervention programs that prevent juvenile delinquency and child maltreatment
    - Works with community partners to identify needs and develop/modify programs

By 2007, DFPS expects to:

- Phase in 179 new caseworkers for APS (beginning 9/2006)
- Develop multidisciplinary forensic training for CPS investigation staff (2006)
- Implement revised minimum standards for residential operation and child-placing agencies, (9/2006-12/2006) and assign preliminary weights to minimum standards for residential operations (2007)
- Implement the Healthcare Delivery Model for children in foster care (2007)
- Transition to first region for outsourcing (12/2007) and award contactor for Independent Evaluator to assess the effectiveness of the Independent Administrator and transition to outsourcing in the first three regions (2007)

The Department of Aging and Disability Services (DADS)-

Established in September 2004, DADS administers a number of programs for community care through: Medicaid home and community based waivers, community attendant and day activity services and primary home care -for institutional care such as Nursing Facilities and Intermediate Care Facilities for Person with Mental Retardation (ICF/MR)- and other community services to individuals who are aging and/or have a disability (cognitive and physical).[93]

As a result of Senate Bill 1, 79th Legislature in the Regular Session, 2005, DADS was appropriated $97.9 million in general revenue funds to serve additional persons from the non-Medicaid and Medicaid waiver community services interest lists. ($18.4 million is set for demographic growth and $79.5 million for interest list reduction.) As part of their current initiatives, DADS has reported that since their Legislative Appropriations Request submitted in November 2004, with a total of 115,560 consumers on the interest list, community services program interest lists have been reduced by a total number of 40,757 consumers or approximately 35%. [94]

Other important initiatives for DADS, mentioned previously are the idea of Self-Determination and Consumer Direct Services (CDS). DADS offers a range of CDS service delivery models:

- The **CDS Option** is a service delivery option in which an individual or legally authorized representative (LAR) employs and retains service providers and directs the delivery of program services. The CDS option will be expanded across all DADS waiver programs during 2007.
- **Agency with Range Of Service Delivery Models Choice Pilot (Service Responsibility Option [SRO]),** available in certain parts of the state, provides consumers control selecting, training and supervising personal care attendants but the provider agency keeps the fiscal functions and the responsibility for providing substitute attendants and administrative personnel functions.
- The **Traditional Agency Option** offers the least amount of consumer involvement as the individual entrusts the provider agency to make decisions, with consumer input, regarding the selection, supervision, and training of attendants.
- **Person Directed Planning (PDP)** focuses on developing a personal support plan that is directed by the resident of the state school or their LAR. The PDP model is currently being piloted at Abilene and Lubbock state schools. Statewide training for implementation at all other facilities is scheduled for January, 2007.[95]

The Texas Promoting Independence Initiative supports allowing an individual with a disability to live in the most appropriate care setting available. The Promoting Independence Plan, which is required to be revised every two years in advance of the legislative session, aids with the success of the initiative. To help HHSC make revisions to the plan, an advisory committee was formed and has begun to prepare 2007 policy recommendations to HHSC by 9/2006, as well as providing an annual stakeholders' report with status updates on the progress of the plan. HHSC will submit the third revision of the plan to the Governor and Legislature on December 1, 2006.

*(*Money Follows the Person Initiative is part of DADS current initiatives and was previously noted in report*)*

DADS has reported Quality Improvements in the following:

- Adapted the nursing facility program systematic literature review process for developing evidence-based best practices in clinical quality improvement to the full range of DADS

populations.

- Expanded the nursing facility quality review process to include personal outcome surveys for individuals and family members in all DADS Medicaid waiver and Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) programs.
- Initiated, as a result of S. B. 1839, 77th Legislature, Regular Session, 2001, a pilot of on-site technical assistance in the state schools in order to identify common quality issues in the ICF/MR setting and develop evidence-based best practice resources for all ICFs/MR.
- Through the technical assistance program, the department has been able to dramatically decrease the use of restraints in nursing homes and to significantly improve nursing home resident vaccination rates. [96]

As noted in the DFPS initiatives section, DADS now has statutory authority over the Guardianship Program, and no reported disruption in services to individuals occurred. The number of referrals to DADS guardianship has increased due to the rising number of intakes to APS and the Senate Bill 6 reform.

According to DADS, the number of active guardianships increased from 656 in December 2004 to 805 as of May 31, 2006, representing an increase of approximately 23%, without a corresponding increase in funding for additional state staff or contract guardians.

With newly attained authority over the Guardianship Program, DADS has taken steps toward program improvements and reform by developing a comprehensive quality assurance program that includes standards for future contract monitoring, and conducting quality assurance visits to obtain baseline information on the performance of DADS regional guardianship staff in order to develop future evaluation standards. An evaluation of the current assessment process and procedure will be done as well, to ensure an accurate assessment of a person's need for guardianship. Twenty-eight guardianship staff will be certified as Registered Guardians through the National Guardianship Foundation. A new data management system for regional and state offices staff will be implemented in order to coordinate new changes.

Future DADS Initiatives:

Medicaid Waiver Optimization

With oversight and administration over seven Medicaid 1915(c) waiver programs, DADS is initiating a study of feasibly combining 1915 (c) waiver programs and their services, along functional need lines, with consideration of service rates appropriate to the level of need of the individuals served. This study will examine efficiencies in administration; service definitions; case management, and appropriate rate levels for services.[97]

> *These waiver programs provide services and supports in the community to people who qualify for care in nursing facilities or an ICF/MR or a related condition, and vary significantly in service delivery and administration.*

According to DADS, streamlined and standardized regulatory services would also benefit consumers, providers, and the state. DADS will look for legislative direction to help establish

consistent licensure periods for all regulated facilities and adjust licensing fees accordingly. DADS will look to standardize: Timelines for submittal of license renewal applications to 45 days before the expiration of the license; The list of violations for which an administrative penalty may be imposed without affording a right-to-correct; and Late fees for failure to make timely payment into the trust fund.[98]

The Department of Assistive and Rehabilitative Services (DARS)-

DARS' main mission is to make certain that Texas with disabilities, both children and adults can eventually function independently, by making employment opportunities and disability services readily available. In order to sustain its mission to its population, DARS has focused on increased resources, early detection, improved oversight, and increased funding in its service areas.

Current Initiatives:

In order to increase resources for their deaf and hard of hearing consumers, DADS added $1.2 million in all funds for deaf and hard of hearing services by matching the Federal Vocational Rehabilitation Grant.

Deafness Resource Specialists were expanded from 11 to 15, and funded 7 contract specialists across the state for the Hearing Loss Resource program. Another key player is the DARS State Coordinator for the Deaf, whose role has been broadened to help with resource increases.

Escalation in the Vocational Rehabilitation Program is apparent for the deaf and hard of hearing in:
specialty caseloads - from 28 in 2004 to 41 in 2006
consumers - from 6% in 2004 to nearly 9% in 2006
proportion of funds - from 8% in 2004 to almost 10% in 2006 [99]

In addition, DARS has begun to work on early detection of hearing loss in infants, after receiving a grant from the Health Resources and Services Administration (HRSA). The grant allows DARS to access newborn hearing screening results and identify infants with hearing loss earlier than was previously possible.

In line with its fellow agencies, DARS has devoted efforts to improve and expand contract management support and oversight to their service delivery areas, by expanding best practices and technical assistance, and standardizing contract terms and contractor performance requirements to help reduce complexity.

DARS reported an increased funding to the Independent Living Services program, by increasing reimbursements from the Social Security Administration (SSA). Reimbursements for FY 2005 were increased by an additional $1 million, a 25% increase over FY 2004 levels, and an additional $1.9 million for FY 2006, which resulted in a 39% increase over FY 2005. Trends suggest that funding will continue to increase.[100]

DARS will look toward implementing initiatives under the federally mandated Individuals with Disabilities Education Act and the Rehabilitation Act, by expanding school-to-work transition services. They have begun by adding 95 additional counselors to serve students with significant and general disabilities. DARS is also a member of the Texas Education Agency's P-16 Council for pre-kindergarten through undergraduate education, in order to ensure that long rang plans and education programs for the disabled are achieved in public education. As part of ensuring the success of transitional services programs, DARS has committed to strengthening its relationship with the Texas Workforce Investment Council and the Texas Workforce Commission as well.

Lastly, DARS sets aim to increase state matching funds to draw down available federal grant funds, like the Vocational Rehabilitation Grant.

These four agencies work in collaboration to serve a population of equally vulnerable Texans and have similar goals in mind; to increase service area access and intake, and ensure accountability in quality assurance to the state and their customers; while at no expense to the taxpayer.

IN CLOSING:

Comprehensive reforms that were made in the 79th Legislature were intended to be rolled out in a managed timeline. It will take years for Texas to experience the full effect of the reforms, but the Committee has seen what it projected to see at this point in time.

The Committee has studied and found that foster youth not only need the appropriate transitional resources to prepare for adult living, but need to know that support is available specifically for their population. The Northwest Study, an **eye-opener**, gave an in-depth look into the world of foster care and ways we can help make it more effective; which has already improved the Northwest Region's foster system on the whole significantly. **Casey Family Programs, the Foundation that backed the Northwest Study, has informed the Committee that a similar study will be completed in Texas in the near future.**

The mental health system in Texas, as shown, has an immense impact on the state. Our jails, hospitals, courts, and wallets are all paying the price of a deficient crisis intervention system for people with severe mental illnesses. Current strategies, such as RDM and jail diversion have begun to address the problem, but it is still just the beginning.

Due to the proposed federal policy changes, many Texas may soon find themselves ineligible for Food Stamps if they currently receive TANF non-cash assistance. HHSC predicts an annual loss of over $14.4 million in Food Stamp benefits to families whose benefits will be denied, creating a major impact on vulnerable Texans. Preparation plans for such impacts are necessary. Though challenges have arisen for HHSC in the state's new integrated eligibility system for food stamps, Medicaid, and TANF, results prove that the new system will be more accessible for applicants, more efficient, and more cost effective in the long run.

The foundation of reforms for vulnerable Texans has been laid. Where we build from here, is in the hands of the members of the Eightieth Legislative Session.

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