HOUSE COMMITTEE ON HUMAN SERVICES
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2008

A REPORT TO THE
HOUSE OF REPRESENTATIVES
81ST TEXAS LEGISLATURE

PATRICK ROSE
CHAIRMAN

COMMITTEE CLERK
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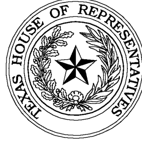

Committee On
Human Services

December 17, 2008

Patrick Rose
Chairman

P.O. Box 2910
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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 Eightieth Legislature hereby submits its interim report including recommendations for consideration by the Eighty-First Legislature.

Respectfully submitted,

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Rob Eissler

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INTRODUCTION

At the beginning of the 80th 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: Patrick Rose, Chair; Susan King, Vice Chair; Elliott Naishtat; John Davis, CBO; Rob Eissler; Bryan Hughes; Abel Herrero; Tan Parker; and Paula Pierson.

During the 80th Regular Session, this committee considered legislation relating to the Children's Health Insurance Plan (CHIP), Texas' integrated eligibility and enrollment system, Child Protective Services (CPS), long-term care for the aging and persons with disabilities, and the Temporary Assistance for Needy Families (TANF) and food stamps programs. Through the public hearing process, the committee became increasingly aware of the need to continue CPS Reform and to prepare more effectively to provide essential services to the state's aging population.

1. Child Protective Services Legislation

In 2005, the Texas Legislature focused attention and resources on the state's struggling CPS system, passing SB 6, a comprehensive CPS Reform bill. Among other provisions, SB 6 focused more resources on investigations of child abuse and neglect and included a directive to privatize many CPS functions. In 2007, SB 758, sought to revise the more unworkable provisions of its predecessor and implemented a second phase of CPS Reform. While SB 758 contained numerous directives, some of the most significant included:

- Reversing the 2005 directive to institute an independent administrator;
- Removing the 2005 mandate to privatize case management services, instead opting for a case management pilot project involving 5 percent of cases statewide;
- Establishing a program to provide in-home support for families in which poverty is the primary underlying cause of neglect;
- Studying the impact of educational reimbursement and targeted recruitment on workforce retention;
- Creating a searchable database for child-placing agencies (CPAs) to report and check information on a foster or group home that has been closed, as well as requiring foster homes transferring to a new CPA to notify the CPA of prior licensing violations;
- Establishing a Committee on Pediatric Centers of Excellence;
- Directing the Department of Family and Protective Services (DFPS) and the OneStar Foundation to increase the number of foster families through faith-based recruitment;
- Increasing the adoption subsidy for youth who would otherwise remain in long-term foster care;
- Establishing public prekindergarten eligibility for any child who has been in the conservatorship of DFPS;
- Requiring DFPS to consult with a child’s caseworker, attorney ad litem, guardian ad litem, and/or Court Appointed State Advocate (CASA) volunteer whenever possible before making a placement decision; and
- Directing DFPS to develop a CPS Improvement Plan.

In addition to SB 758, the House Committee on Human Services considered, and the 80th Texas Legislature passed, the following bills related to CPS and child welfare:

- **HB 662** directs DFPS to work with the Interagency Coordinating Council for Building Healthy Families (ICC) to develop a long-range strategic plan for child abuse and neglect prevention services and dedicates money from the Prevention of Child Abuse and Neglect Trust Fund in general revenue (GR) solely to its intended purpose;
- **HB 1972** allows an attorney ad litem to meet with a child via telephone/video conference;
- **HB 2580** allows DFPS to appoint a guardian to provide medical consent on its behalf;
- **HB 2670**, which was enacted as an amendment to SB 723, allows DFPS to access reports of family violence for individuals applying for a foster home license and requires DFPS to create a database of all licensed foster care homes identifying those currently providing services;
- **HB 3008** establishes a pilot in Tarrant County to provide transition mentoring for foster youth by contracting with a private or non-profit entity;
- **HB 3505** requires that judges and other judicial officers be instructed on handling cases of child abuse and neglect;
- **SB 450** prevents the use of foster children in pharmaceutical research studies except in cases where a clinical trial represents the only possibility of treatment;
- **SB 723** requires DFPS to note for future study when kinship placement is not possible due to financial hardship; and
- **SB 813** provides assurances that local Harris County child welfare entities can continue to provide CPS services, regardless of future changes in the state's privatization plan.

1.1 Appropriations
The approved budget for FY 2008-2009 included $11 million for a new post-psychiatric hospitalization rate to provide step-down services to foster children with complex needs, $13.4 million in GR to increase foster care reimbursement rates, and $4.6 million additional dollars for prevention services.

2. Long-Term Care Legislation
The aging population and persons with disabilities rely on the critical continuum of long-term care services in Texas, but numerous gaps exist. While both public and private sectors play a role, Medicaid is currently the largest single payor of long-term care services. For this reason, the policy and budgetary decisions of the Texas Legislature have a substantial impact on the quality and availability of long-term care services for all Texans.

The House Committee on Human Services considered numerous bills related to long-term care. The following were ultimately approved by the 80th Texas Legislature:

- **HB 52** restores the personal needs allowance received by Medicaid recipients that was cut in 2003;
- **HB 1168** instructs DADS to prepare a report addressing the potential need to regulate boarding houses, which are often home to persons with mental illness and/or disabilities;
- **SB 27** requires DADS to work with an interagency task force to ensure appropriate care settings for persons with disabilities and moves the administration of the Community Living Options Information Process (CLOIP) for adult residents of state schools to local

mental retardation authorities (MRAs);
- **SB 131** authorizes the formation of family councils at nursing homes to improve resident care;
- **SB 199** expands the list of offenses precluding an individual from working as a caregiver for a person with long-term care needs;
- **SB 1766** improves access to consumer-directed service models for persons with disabilities; and
- **SB 22*** seeks to incentivize the purchase of long-term care insurance through the establishment of a Long-Term Care Partnership program, the implementation of asset disregards for purchasers, and the creation of an expansive public awareness campaign.

2.1 Appropriations
The Legislature appropriated funds for FY 2008-2009 to increase rates for long-term care providers, improve staff-to-client ratios at state schools, and support a greater number of individuals with disabilities in community settings. Specifically, the approved budget included the following:

- Rate increases of 6, 8, and 9.3 percent, respectively, for community care providers, nursing facilities, and intermediate care facilities (ICFs);
- $107 million in GR to reduce interest lists;
- An additional $48.8 million in GR to hire state school staff and move residents into HCS waiver slots;
- An additional 300 Promoting Independence waiver slots;
- $1 million in GR to establish two Centers for Independent Living (CILs);
- $6.3 million in GR for persons with traumatic brain and spinal cord injuries to access comprehensive rehabilitation services while waiting for waiver slots; and
- $2 million in GR for assistive technology initiative to help persons with disabilities stay in their homes.

3. Interim Charges

The House Committee on Human Services worked diligently to create an interim charge request that would allow it to build on its work from the 80th Regular Session. In response, the Speaker issued six separate interim study charges related either to the CPS system or to the quality and availability of long-term care services and supports.

The committee held five hearings during the 80th Interim Session. On January 24, 2008, the committee heard testimony at the Texas State Capitol to monitor the work of the agencies under its jurisdiction. On February 21, 2008, at the invitation of Representative Pierson, the committee heard testimony on its three CPS charges at the University of Texas at Arlington. On March 13, 2008, at the invitation of Representative Davis, the committee convened in Harris County at the University of Houston Clear Lake to hear testimony on its two long-term care charges. Following these hearings, the committee convened twice in Austin at the Texas State Capitol, on

*Although this bill was considered in the Public Health Committee in 2007, it has a significant impact on the long-term care delivery system.

April 3, 2008, to continue its study of the CPS system, and on May 1, 2008, to take testimony regarding long-term care services.

4. Acknowledgements

The committee wishes to express appreciation to all those who contributed to the interim hearing process and to the development of this report, including the following members of Chairman Rose's and the committee members' staff: Mike Ruggieri, Veronica Lockett, Corey Theurer, Nancy Walker, Deena Perkins, Meghan Weller, Carole Bleakney, Daniel Deslatte, Michael Garemko, Richard Dennis, Amy Loos, and Maureen Perro. The hearings and report would not have been possible without the assistance, research, and testimony of leadership and staff at the Health and Human Services Commission, the Department of Family and Protective Services, the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Department of State Health Services, the Texas Workforce Commission, the Texas Department of Housing and Community Affairs, and the Texas Department of Insurance. Thanks also for the assistance of staff in the Office of the Committee Coordinator, the Office of the Speaker, the Texas Legislative Council, the Legislative Budget Board, and the Legislative Reference Library. The committee would also like to express its gratitude to staff at the University of Texas at Arlington and the University of Houston Clear Lake for their hard work and professionalism, as well as to the agencies, organizations, and individuals who waited long hours to provide testimony at interim hearings.

5. Source Attributions

Except where otherwise indicated, data and information presented in this report were provided by the relevant administrative agency in testimony or follow-up documents.

HOUSE COMMITTEE ON HUMAN SERVICES

INTERIM STUDY CHARGES AND SUBCOMMITTEE ASSIGNMENTS

CHARGE 1: Research strategies to promote permanency and stability for children and families involved with Child Protective Services. Identify any priorities that would improve the adoption process.

CHARGE 2: Explore strategies to support the needs of aging Texans effectively and efficiently. This investigation should include best practices in delaying or avoiding the need for institutionalized care, as well as promoting high-quality services for those who are best served in nursing homes.

CHARGE 3: Evaluate Prevention and Early Intervention programs at the Department of Family and Protective Services that have been funded by the Texas Legislature for the prevention of child abuse and neglect. Consider if higher priority for selection should be given to child or family mentoring or other support services, such as foster grandparents and efforts that assist mothers.

CHARGE 4: Evaluate existing and past efforts by the state for youth transitions in independent living. Recommend improvements to educational, occupational, health, and life skills components of preparation of foster children for adult living.

CHARGE 5: Investigate the need for and potential of respite care programs to delay or avoid institutional placements, thereby resulting in cost savings for the state.

CHARGE 6: Examine compliance issues and concerns of hospices with certification surveys and ability to meet federal standards.

CHARGE 7: Monitor the agencies and programs under the committee's jurisdiction.

CHARGE 1

Research strategies to promote permanency and stability for children and families involved with Child Protective Services. Identify any priorities that would improve the adoption process.

The Department of Family and Protective Services (DFPS) is an agency comprised of four divisions: Adult Protective Services (APS), Child Care Licensing (CCL), Prevention and Early Intervention (PEI), and Child Protective Services (CPS). Each division plays a distinct role in protecting the state's most vulnerable citizens from abuse, neglect, and exploitation. Their roles may be generally described as follows:

- **APS** investigates incidences of abuse, neglect, and exploitation of adults who are elderly or have disabilities;
- **CCL** regulates all child-care operations and child-placing agencies (CPAs) and monitors their implementation of minimum standards;
- **PEI**, described in greater detail in the report on the committee's third interim charge, administers funding to and monitors community-based programs that seek to prevent juvenile delinquency and child maltreatment; and
- **CPS**, the central focus of this charge, is responsible for investigating reports of suspected abuse, neglect, and exploitation of children, working with families to help eliminate problems leading to abuse and/or neglect, placing and monitoring children in foster/adoptive homes, and helping youth in foster care make the transition to adulthood.

1. The Child Abuse and Neglect Case

CPS is by far the largest division of DFPS and is responsible for investigating reported cases of child abuse and neglect, as well as coordinating and monitoring services provided to children in the conservatorship of the state. In FY 2007, statewide intake received more than 240,000 reports of suspected abuse or neglect involving children. As a result of the CPS investigation process, more than 100,000 children were confirmed victims, and almost 16,000 were removed from their homes, at least temporarily.[1]

Ensuring that each of these children ultimately finds a safe, stable, and permanent home is of critical importance. Whether they ultimately remain with or return to their parents, are placed with relative kinship caregivers, enter the foster care system, or find an adoptive family, the quality and stability of the placements they experience have a significant impact on their future success. In support of these goals, the committee's recommendations should be informed first by a clear understanding of the statutorily defined process of a child abuse investigation, the involvement of the court and other actors, and recent legislative changes related to the child welfare system. This information is provided as background in this section of the report.

1.1 Reporting Suspected Child Abuse

DFPS operates a toll-free, statewide telephone reporting system, known as Statewide Intake, as a way for the public to report abuse 24 hours a day, 365 days a year. In a non-emergency situation, individuals may also report suspected abuse via the DFPS website.

In cases of immediate danger to a child's safety, reporters are instructed to call 9-1-1. All reports are confidential. While some individuals choose to make anonymous reports, this was the case for fewer than 5 percent in FY 2007.[2]

Upon receipt of a telephone or internet report, intake staff initially determines whether an allegation meets the statutory definition of child maltreatment. This process involves gathering as much information as possible from the reporter and checking agency databases to determine if the family has an open case with CPS or a history of substantiated abuse or neglect. If the statutory definition is met, the report is given a priority and assigned for investigation or assessment. A priority one categorization is given to high-risk reports and is investigated within 24 hours. In the case of a priority two assignment, an investigation is initiated within 72 hours.

1.2 Investigation

An investigation is conducted if an allegation meets the statutory definition of abuse or neglect to determine if a child has been or is at risk of being harmed. CPS investigative caseworkers have 30 days from the receipt of a report to complete the initial tasks of an investigation unless a supervisor grants an extension. During this time, background checks are completed, home visits are conducted, and the child's parents, teachers, friends, family, and other relevant contacts are interviewed.

Upon completion of the investigation, the caseworker must determine the disposition of the report based on the information gathered, child abuse and neglect statutes, and agency guidelines. The caseworker may make any of the following four determinations:

- **Ruled Out** (allegations of abuse and/or neglect are unfounded);
- **Reason to Believe** (abuse and/or neglect occurred as indicated by a preponderance of evidence);
- **Unable to Determine (**there is evidence to support the report, but not enough to determine); or
- **Unable to Complete** (occurs in cases where a family moves to an unknown location).

1.3 CPS Intervention

After a thorough investigation, all cases of alleged abuse and/or neglect are assigned a risk. If there is evidence of risk, the agency conducts an assessment to determine whether the child can remain safely in home with supervision or support services. Based on this assessment, there are three possible outcomes:

- **Removal** from the home;
- Referral to **Family-Based Safety Services** (FBSS); or
- Child remains at home under the **joint managing conservatorship** (JMC) of CPS.

1.3.1 Emergency Removal

If risk assessment indicates that the emergency removal of a child is necessary, CPS

works with the local district attorney (DA) or other appropriate legal entity to file a case petitioning the court for removal of the child from the home and placement under the supervision of CPS. Generally, in emergency situations, the agency will remove the child and place him or her in emergency or temporary foster care before receiving the court order. The agency has one business day to file a petition to have a judge sign an emergency order, at which time the judge will schedule an adversary hearing to take place within 14 days.

On July 28, 2008, the Fifth Circuit Court of Appeals issued an opinion in *Gates v. Texas Department of Protective and Regulatory Services* that will require DFPS to obtain a court order prior to removal in a much larger portion of cases. According to the *Gates* decision, DFPS must be able to demonstrate that a child is in "imminent danger of physical or sexual abuse if he remains in his home." [3] This will require CPS caseworkers to wait 24 hours to obtain a court order for removal rather than executing an emergency removal in more situations than in the past.

Once a child is removed from the home, that child and his or her parents become formally involved with the family court system. The child is placed in the temporary managing conservatorship (TMC) of the state and becomes a ward or dependent of the court. At this point, the child and his or her family are assigned a conservatorship (CVS) case worker from CPS, ending the investigative caseworker's role. The CVS caseworker, along with the family, develops a case plan detailing the types of services the child and family will receive, such as parenting classes, mental health or substance abuse treatment, and family counseling. The case plan should explain clearly the goals for reunification with the family, including visitation schedules and a target date for a child’s return home, as well as concurrent plans for alternative permanent placement options should reunification goals not be met. The judge must approve the initial placement and reunification plan at the status hearing, which takes place within two months of removal.

1.3.2 Family-Based Safety Services

In cases where risk is indicated, but there is no need for emergency removal, the case is referred to FBSS. While assigned a FBSS caseworker, the child remains in the home or may be voluntarily placed with an alternate caregiver. Targeted services are provided to the family to reduce risk of harm to the child. Indicated services are varied and can range from engaging extended members of the family to providing financial aid to meet basic needs in cases where poverty is a primary contributor to child maltreatment. If risk to the child is reduced to a level where the child is safe in the home, the case is closed. If risk of harm is not reduced or managed, it may become necessary to remove the child legally, in which case the aforementioned removal process would be initiated.

1.3.3 Joint Managing Conservatorship

In rare cases, children remain in the home with a court order granting JMC to the agency. While JMC is not generally a preferred option, it may be used in the case of a family that is unable to care for a child with disabilities or a parent with disabilities who is unable to provide adequate care. Once JMC is granted, a child is in a foster or kinship placement, but the family retains joint conservatorship.

1.4 Role of the Court

If the CPS case involves a court order, the courts are required by law to remain involved in that case beyond simply issuing the order. The process, as outlined in statute, is described below in greater detail.

The first hearing, or adversary hearing, takes place no more than 14 days after removal and is when the court first determines whether the child has been abused or neglected. If the judge does not determine that child abuse or neglect has occurred, the judge orders reunification of the family, and the case is closed. If the judge determines that abuse or neglect has occurred, the judge will decide the initial placement, which may be with family, friends, or in foster care.

At the second hearing, or status hearing, CPS provides recommendation to the judge regarding the family's agreed-upon service plan. The parents and their attorneys then have the opportunity to inform the judge of any concerns related to the proposed plan. After hearing both parties, the judge orders the required services. The status hearing takes place within two months of removal.

The third hearing, which takes place within four months of removal, is the initial permanency hearing. At this hearing, the judge considers a number of factors. CPS and the family report on the status of the order to complete services, and the judge is generally interested in learning of any service plan changes that may be needed. Involved parties (e.g., CVS caseworker, attorney ad litem, guardian ad litem, foster parents) also provide an update regarding the well-being of the child. If the family is making adequate progress towards meeting the requirements of the service plan, and it is in the best interest of the child, the judge may decide to allow the child to return home with CPS supervision. If the family is not making adequate progress toward the service plan, other options for long-term placement of the child are discussed. After the initial permanency hearing, additional permanency hearings take place at least every six months to assess the family's compliance with the court order, the child's well-being, and whether the service plan should be altered.

In most cases, the final hearing takes place within one year of removal, as CPS is granted 12 months by law to work with the parents towards reunification. At this hearing, the judge may make one of four decisions:

- **Extension,** in which case the judge may grant a one-time, six-month extension to allow CPS to continue working with the family for a total of 18 months;*
- **Reunification**, in which case the child returns home, and CPS remains involved for up to six months to monitor the family's progress;
- **Termination of Parental Rights** (if the birth family does not complete the court-ordered reunification plan), in which case the parents are no longer legally responsible for the child, and CPS retains legal custody; or

* May occur when family has taken steps to cooperate with the terms of the service plan but faces barriers outside their control, such as a waiting list for substance abuse services.

- **Permanent Managing Conservatorship (PMC).** The judge may decide that the situation does not warrant granting CPS's petition to terminate one or both parents' rights. In these instances, CPS is given the legal authority to make decisions regarding the child's future, but the parents' rights are never terminated. As a result, even very young children in PMC are not free for adoption.

1.4.1 Termination of Parental Rights

Once a judge has decided to terminate parental rights, CPS is legally responsible for the care of the child whose parents have lost custody. Generally, there are three possible final outcomes for that child:

- **Adoption,** in which case the child is placed with an adoptive family, and the adoption is ultimately finalized by the court;
- **Kinship care,** in which the child is placed with a legal guardian, often a relative or close family friend; or
- **Long-term foster care,** in which case the child remains in the foster care system, ultimately reaching the age of 18 with no permanent home.

The goal of CPS in all cases where parental rights have been terminated is to find a permanent adoptive or kinship placement for the child, but this is not always possible. This is particularly problematic for children in PMC whose parents' rights have never been terminated. For children in PMC without termination of parental rights and with no available relative placements, the only option is to remain in foster care until the age of 18. Many of these children experience multiple placements, lack a stable relationship with an adult, and generally experience great uncertainty.

1.5 Other Stakeholders

In addition to CPS and the court system, most child abuse and neglect cases involve a number of stakeholders who may influence the ultimate outcome of the case. These stakeholders, as well as the role that each plays, are described briefly below.

1.5.1 Attorney for Parent(s)

When CPS files a lawsuit requesting TMC or termination of parental rights, a parent has the right to a court-appointed attorney under the following circumstances:

- The parent is indigent;
- He or she opposes termination or removal; and
- The court finds that neither parent's interests conflict.

The court assesses whether the parents are financially able to compensate an attorney. In cases where the parent(s) cannot afford an attorney, the county covers the cost.[4]

1.5.2 Attorney Ad Litem

When children and their families become formally involved with CPS, the court is statutorily required to appoint an attorney ad litem to represent the child. Parents are required to cover the cost of representation unless the parents are indigent, in which case

the county is responsible. The court-appointed attorney is required to act as legal counsel for that minor child and to ensure that his or her wishes are represented to the court.

1.5.3 Guardian Ad Litem

State law also requires that the court appoint a guardian ad litem to represent the best interest of the child. In many cases the attorney ad litem serves as both attorney and guardian. While this is generally not problematic for infants and very young children, conflicts of interest can arise when a child's wishes do not align with his or her best interest. For this reason, it is often critical for an individual other than the attorney ad litem to fulfill this role.

1.5.4 Court Appointed Special Advocate

Court Appointed Special Advocates (CASAs) are volunteers appointed by the district courts who are charged with the responsibility of advocating for the best interest of the child. Because CASAs are volunteers (unlike attorneys ad litem), many judges choose to appoint a CASA, when available, to fulfill the role of guardian ad litem. This eliminates the potential conflict of interest to which the previous section alludes without further burdening county resources. In other cases, a judge may appoint the CASA to serve as a friend of the court, a position with less authority than that of guardian ad litem.

CASA volunteers play a vital role in the court process by carrying out the tasks that courts do not have the time, money, or staff resources to complete. Volunteers conduct independent investigations, which include interviewing the child and other persons involved. They collect information that is relevant to the case and present a formal report with placement recommendations to the court. Throughout the hearing process, the CASA monitors the case to ensure that services are provided promptly and adequately.

Any adult with the desire and time to help an abused and/or neglected child can volunteer to become a CASA. There is not a requirement to have a legal background or a degree in social work. A volunteer must pass a criminal background check and complete at least 30 hours of training before becoming a CASA. Responsibilities include the following:

- Interviewing the child and all involved persons in the case;
- Maintaining records of all findings and turning in necessary paperwork once a month;
- Conferring with the director on a regular basis and prior to any final decision;
- Attending all staffings and court hearings concerning the child;
- Discussing court reports with the case supervisor prior to preparing reports;
- Preparing court reports ten days before hearings;
- Monitoring the case to ensure court orders are being carried out;
- Investigating possible placements for appropriateness; and
- Achieving permanency for the child.[5]

1.5.5 Local Law Enforcement

Local law enforcement agencies also play a role in the investigation of abuse and neglect cases. Statute requires CPS to notify law enforcement agencies of all reports of alleged abuse or neglect, and the law enforcement agency determines, independently from CPS, whether to conduct a criminal investigation and whether a criminal violation occurred. In some areas, the local law enforcement agency operates a separate division to investigate child abuse and neglect cases in criminal proceedings.

1.5.6 Child Advocacy Centers

Throughout Texas, 61 Child Advocacy Centers (CACs) serve 148 counties and generally focus a large portion of their resources on child sexual abuse cases. CACs provide a location at which law enforcement, prosecution, CPS, and medical and mental health professionals can work collaboratively to investigate allegations of child abuse. CACs do not function uniformly, but instead operate based on the needs of their community and the size of their service area.

CACs employ a multidisciplinary team approach to forensic interviews so that each child must only tell his or her story once. They provide a place for professionals to receive training, accommodate communities and volunteers who wish to implement prevention and awareness programs, and offer continuing services for children who are recovering from abuse.[6]

1.5.7 Child Welfare Boards

As referenced in Texas' Family Code, child welfare boards (CWBs) are 501(c)3 non-profit organizations operated at the county level under the umbrella of the Texas Council of Child Welfare Boards (TCCWB). Volunteers must be residents of the county and are appointed by county commissioners' courts. Currently, 212 of Texas' 254 counties are served by a CWB. While some CWBs are funded through the county's general revenue, others rely exclusively on external fundraising.

CWBs assist in efforts to educate members regarding adoption and permanency issues through their involvement with the Heart Gallery program. Heart Gallery recruits professional photographers to volunteer their time and skills to help children find adoptive homes. CWBs then work with other community groups to fund printing and mounting, locate exhibition sites, and publicize events in their communities.[7]

In addition, CWBs provide financial support to meet the needs of children in foster care that cannot be met by appropriated state funds. Boards may assist with expenses such as clothing, summer camps, dance lessons, high school proms, class rings, graduation, life kits for transitioning youth, or dorm and apartment items. Recently, the TCCWB received a grant to assist DFPS with the 2008 regional teen leadership conferences for youth in foster care.

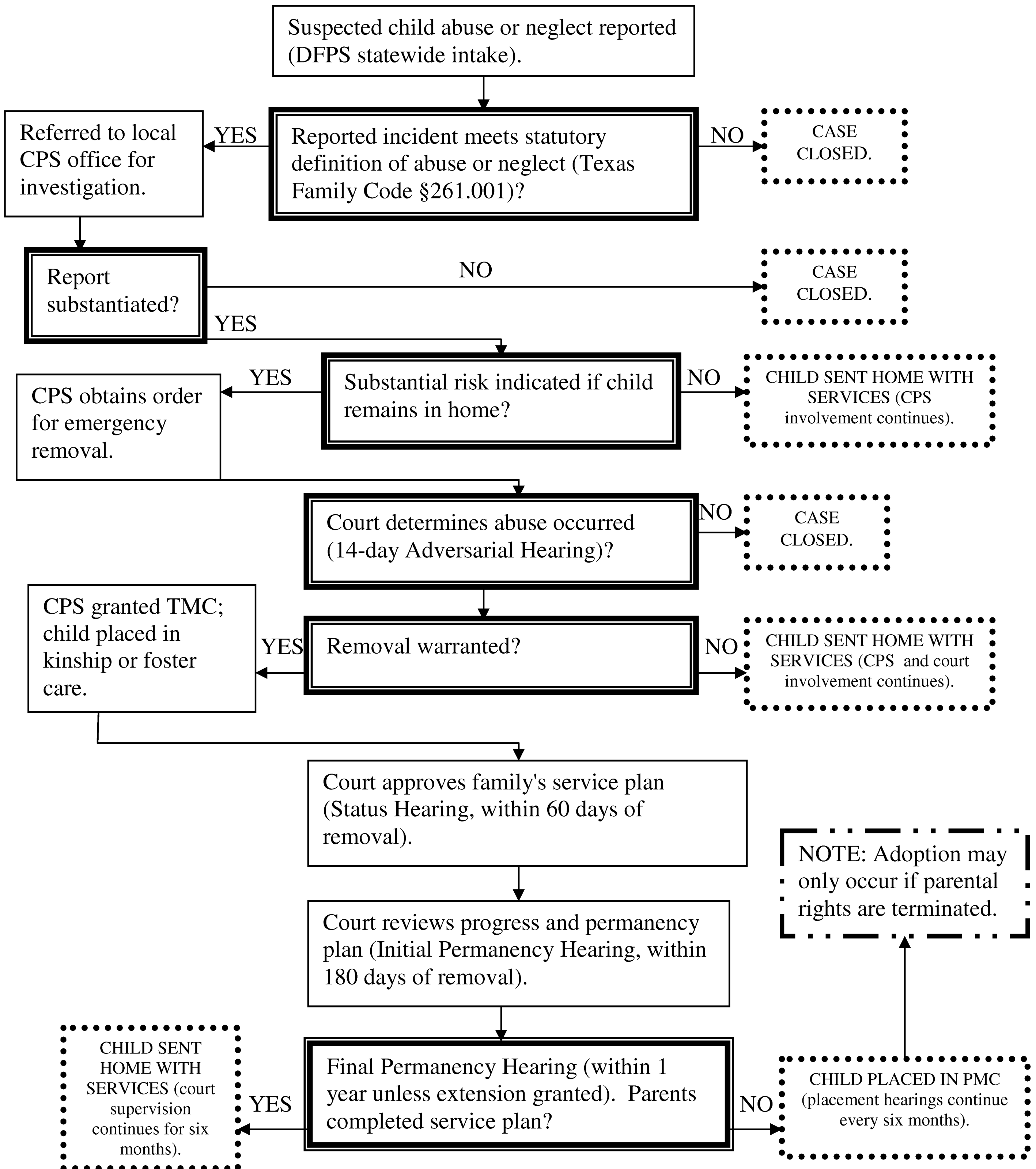
In some counties, the CWB collaborates with the Greater Texas Community Partners to operate a Rainbow Room, an emergency resource center available to CPS caseworkers to help meet the critical needs of abused and neglected children. Stocked with all new

items, Rainbow Rooms provide clothing, shoes, diapers, baby formula, school supplies, and personal hygiene items to children entering foster or relative care, as well as children in their own homes who live below the poverty line.[8]

1.6 Summary

In summary, a child abuse and neglect case consists of multiple stages involving numerous stakeholders, from report and investigation through removal and final determination. Understanding how these fit together and the responsibilities of each entity involved is a critical prerequisite for making recommendations for improvement. Figure 1.1 on page 19 provides a visual representation of the processes and actors described in the previous section.

Figure 1.1 CPS Case Diagram



2. Recent Changes at CPS

Texas' child welfare system experienced tremendous change as a result of legislation during the 79th and 80th Regular Legislative Sessions, often referred to collectively as "CPS Reform." These reform efforts provides a critical foundation from which to address the committee's first interim charge.

2.1 Background

In 2003 and 2004, CPS became the subject of intense scrutiny following several highly publicized abuse and neglect cases that resulted in child deaths. Consequently, elected officials and agency leadership quickly focused on identifying public policy solutions. The following timeline represents the sequence of events leading up to the passage of critical CPS Reform legislation:

- **April 2004 -** The Texas Comptroller released a special report on the foster care system highlighting deficiencies in protecting abused and neglected children in its care.
- **July 2004 -** Governor Rick Perry issued an executive order mandating that the Health and Human Services Commission (HHSC) conduct a systemic review of the CPS program;
- **November 2004** - The House Select Committee on Child Welfare and Foster Care published its recommendations to support DFPS in better fulfilling its mission to protect children from abuse, neglect, and exploitation. Simultaneously, the House Committee on Human Services issued its interim report, which included recommendations to improve prevention efforts and streamline reporting and investigations; and
- **January 2005 -** HHSC released its final report in response to the Governor's executive order. As a result of these and other efforts, strengthening CPS' investigative process became a legislative priority.

2.2 Reform Legislation

In 2005, the 79th Texas Legislature passed SB 6, which coordinated recommendations made to legislative committees with those from HHSC's 2005 report. Among other provisions, SB 6 directed DFPS to:

- Privatize substitute care and case management services, including contracting with independent administrators to coordinate substitute care and case management services within each geographical region;
- Reduce CPS investigative caseloads and improve the investigative process, including the use of highly skilled caseworker screeners and better coordination with law enforcement;
- Strengthen family preservation and prevention services;
- Support relative and fictive kin* placements;
- Improve transitional services for foster youth aging out of care;

* Used to refer to an unrelated individual who has an emotionally significant relationship with a foster child.

- Develop education and health passports for children in foster care to enhance the continuity and quality of their education and medical care;
- Develop a comprehensive medical services delivery model; and
- Strengthen child-care licensing.

In 2007, the 80th Texas Legislature passed SB 758 in response to stakeholder and agency feedback in order to refine and expand changes made during the previous legislative session. Among other provisions, SB 758 scaled back the outsourcing requirements of SB 6, including the mandate to contract with independent administrators and privatize case management services. Additionally, this legislation directed CPS to:

- Maintain children safely in their homes by expanding Family Group Decision-Making, reducing caseloads for FBSS caseworkers, and enhancing in-home supports;
- Reduce the length of time children spend in state care through enhanced family-based services, reduced caseloads for CVS caseworkers, increased support for kinship caregivers, and streamlined court services and record preparation for adoption;
- Improve the quality and accountability of child-care licensing and investigations;
- Expand placement quality and capacity;
- Streamline criminal history background checks;
- Address disproportionality;
- Provide adoption subsidies for children likely to remain in foster care;
- Develop Pediatric Centers of Excellence;
- Contract with a private provider to provide case management services in up to 5 percent of CPS cases; and
- Evaluate the potential of education reimbursement and targeted recruitment to reduce workforce turnover.

3. Current Context

Given the magnitude of change the child welfare system has experienced in only a few years, an immediate third wave of comprehensive reform mandating significant changes to existing policy and procedure would likely be counterproductive. DFPS will require time to implement current statute and, along with the Legislature, assess the impact of policy changes on the system before attempting to execute yet another round of sweeping initiatives. Nevertheless, the Legislature should always endeavor to improve the child welfare system and explore new approaches to intractable problems. Currently, there are at least two additional compelling reasons, as described below, for sustained legislative focus on CPS.

3.1 Converging Interest

Texas' child welfare system stands to benefit greatly from the recent convergence of interest regarding how best to protect children from abuse and neglect. In addition to interest within the executive and legislative branches (e.g., the Governor's executive order, the work of the House Select Committee in 2004, and the interim charges issued in 2007 to both the House and Senate committees with jurisdiction over DFPS), the judicial

branch has turned its attention towards CPS.

In November 2007, under the leadership of Justice Harriet O'Neill, the Texas Supreme Court established the Permanent Judicial Commission for Children, Youth, and Families (Appendix B), which seeks to improve the judiciary's ability to respond to the needs of children and families involved with CPS. Outcomes for children and families in the CPS system depend on a strong, fully functional, and well-informed family court system, which can only occur when courts, attorneys, and CPS communicate effectively, when information systems are aligned, and when judges and attorneys are prepared to address the needs of this population. The Legislature now has the opportunity to learn from this new judicial committee and its legislative subcommittee in order to make needed statutory changes to improve outcomes for children.

3.2 Federal Scrutiny under the Child and Family Services Review

DFPS is currently struggling to meet federal requirements set forth in the federal Child and Family Services Review (CFSR) and will require the sustained support of the Texas Legislature to meet these new standards. The CFSR is a collaborative federal-state effort designed to ensure the quality of child welfare services in each state. The United States Department of Health and Human Services Children's Bureau, Administration for Children and Families (ACF) administers the review and works with each state in developing a Program Improvement Plan (PIP) to address deficient areas. States are evaluated according to seven outcomes and seven systemic factors.

3.2.1 Outcomes

According to the standards set forth in the CFSR, the state is required to make substantial progress towards achieving the following outcomes for children in its care:

- Protection from abuse and neglect;
- Safe maintenance in the home whenever possible;
- Permanency and stability in living arrangements;
- Preservation of family relations and connections;
- Enhancement of families' ability to provide for their children's needs;
- Appropriate educational services; and
- Adequate physical and mental health services.

3.2.2 Systemic Factors

In addition to the aforementioned outcomes, the state's child welfare system is evaluated based on the following seven systemic factors:

- Statewide information system;
- Case review system;
- Quality and assurance program;
- Staff and provider training;
- Service array;
- Agency responsiveness to the community; and
- Foster and adoptive parent licensing, recruitment, and retention.

3.2.3 Round One

Texas underwent its first-round CFSR evaluation in February 2002, achieving one outcome (Permanency 2) and each of the seven systemic factors. The PIP period for Texas concluded in March 2007, at which point the state had achieved four of six outstanding outcomes in its PIP. Subsequently, DFPS entered into negotiations with ACF, provided additional information, and successfully achieved one of the two outstanding outcomes (Permanency 1). DFPS was ultimately unable to meet the PIP goal for Well Being 1 (ensuring that 90 percent of children in care and their parents receive monthly visits from a CPS caseworker). Consequently, the federal government has assessed a financial penalty, which DFPS has appealed.

3.2.4 Stakeholder Input

In the process of completing the first round of the CFSR, DFPS hosted two stakeholder meetings as part of a self-assessment exercise. Participating stakeholders, including city, county, state, and federal agencies, community and advocacy organizations, universities, service providers, parents, foster youth and alumni, and the legal and judiciary communities, identified a number of areas in which the department is effective, as well as several areas of concern. Of note, a number of challenges identified by stakeholders closely mirror the preliminary findings of the second CFSR, including:

- Caseloads;*
- Retention of staff and foster parents;
- New minimum standards;
- Barriers in foster care system (e.g., license fees and timeliness);
- Low funding for mental health services;
- Achieving permanency; and
- Inconsistency in the interpretation of policy and regulations.[9]

3.2.5 Round Two

The assessment for the second round of the CFSR was completed in January 2008, and the state will be required to submit another PIP, this time with an even higher standard for improvement. For this reason, and because the stakes for DFPS are so high, it is imperative that the Legislature continue to support the agency's efforts to work with the federal government and to improve services for children in its care.

Preliminary comments from the second CFSR noted a number of systemic strengths. Specifically, the statewide information system (Information Management Protecting Adults and Children in Texas, or IMPACT), quality assurance system, and staff training initiatives were generally viewed as providing positive results. Additionally, ACF applauded the work of DFPS to achieve diversity among and streamline the criminal records check process for its foster and adoptive parents, as well as its efforts to partner with other stakeholders, such as the Texas Supreme Court.

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* High caseloads may result in inadequate assessment and infrequent caseworker visits, both of which were identified as problems by ACF reviewers during the second CFSR.

In addition to the aforementioned strengths, ACF reviewers called the agency's attention to the following shortcomings:

- Inadequate foster and adoptive capacity for older children with more complex needs;
- Problems related to the implementation of new minimum standards;
- Workforce turnover;
- Retention of foster and adoptive families;
- Waiting lists for mental health and substance abuse services;
- Significant number of children in PMC without termination of parental rights; and
- Ineffective communication with providers.

Preliminary data from the case review sites (Harris, Dallas, and El Paso counties) indicated continued problems related to the permanency and well-being outcomes. Specifically, ACF reviewers noted the following:

- PMC often stops movement towards a permanent home;
- Concurrent planning for permanency often occurs only on paper;
- Placements are unstable, and too many children are placed out of county;
- Children are being placed permanently with relatives before adequate efforts have been made towards reunification;
- Inadequate assessments of children and families;
- Services not linked to assessments;
- Inconsistent caseworker visits; and
- Lack of effort to engage absent parents.

Once ACF issues its final report of findings, for which there is currently no expected completion date, DFPS has 90 days to submit its PIP. Although the final report has not been issued, the agency has begun to work with stakeholders and ACF reviewers to develop a preliminary draft of the PIP.

4. Defining the Problem

The role of CPS is multifaceted. First, it is charged with investigating abuse and neglect. Second, it is responsible for intervening and protecting children when necessary and under the supervision of the court. Finally, in its conservatorship capacity, the agency is accountable for developing and providing safe and stable placements for the children in its care. What's more, the overall outcome for children involved with CPS is dependent upon a number of factors outside the jurisdiction of DFPS, including the decisions of judges, the actions of law-enforcement agencies, the ability of private providers to furnish appropriate services, the quality of legal representation for children and parents, and the availability of CASA volunteers to advocate for the best interest of children. While the department cannot directly control each of these factors, it does play a central role in the process and has the ability to effect positive change.

Enhancements to promote placement stability should be the focus for children placed in

both the temporary and permanent conservatorship of DFPS. As the many facets of a child abuse and neglect case are placed in motion—from family service plans, court hearings, and visitations, to searches for absent parents, the exploration of kinship placement possibilities, and concurrent permanency planning—the state is responsible for quickly finding the best possible placement to meet the child's needs, as close to home as possible, with his or her siblings if possible, and resulting in minimal disruption of education, personal and familial relationships, and medical care. Currently, too many children are juggled from emergency shelter to kinship placement to foster care to residential treatment center, from county to county, from school to school, and without the continuous involvement of a caring adult. This significant emotional, geographic, and educational disruption is severely detrimental to a child's well-being and development.

For the population of children in PMC, the issue of permanency is critical. Reunification with the parent is no longer a possibility for these children, but there are a number of alternatives that are preferable to aging out of the foster care system, such as adoption (if parental rights have been terminated) or permanent placement with stable relatives or fictive kin. All too often, children remain in PMC for months and even years without finding a permanent home.

Stakeholder and CFSR input has allowed the committee to identify the following key challenges that CPS faces as it attempts to find appropriate placements and maintain children in those placements:

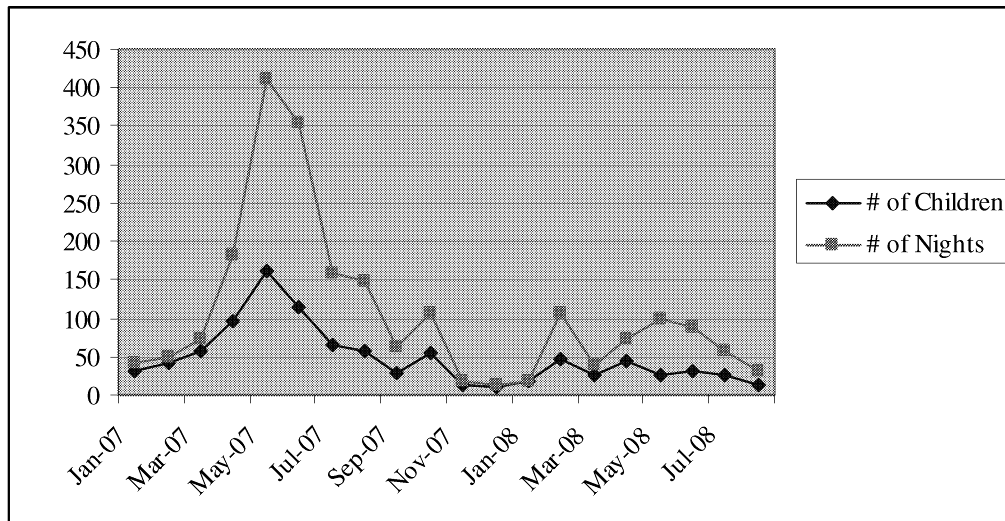
- First, **inadequate capacity** exacerbates instability for children in foster care;
- Second, **systemic instability**, including chronic turnover among the CPS workforce, barriers to successful placements, a lack of advocacy for children in PMC, and education instability, thwarts many of the agency's best efforts to provide continuity of care and, ultimately, permanency; and
- Third, for the large number of children placed in PMC without termination of parental rights, **long-term foster care** is too often the designated permanency plan.

Addressing these barriers to achieving permanency and stability will enhance the ability of DFPS to meet federal requirements and, more importantly, result in better outcomes for children in the state's care.

4.1 Inadequate Capacity
In January 2007, DFPS began tracking the number of children who were forced to sleep in CPS offices and other non-placement settings (e.g., hotels and administrative areas of emergency shelters) as a result of the inability to find appropriate placements. Prior to that time, children were placed in offices occasionally and for short periods in emergency situations. However, the department noted that the phenomenon was becoming increasingly regular, peaking in May 2007, during which 160 children spent 410 nights in offices or other non-placement settings (Figure 1.2).

A second worrying trend that has surfaced during the past several years is the increasing number of children in care who are placed in state school facilities—from three in January 2003 to 28 by May 2008. Many of these children have complex behavioral health needs in addition to cognitive and/or developmental disabilities, and many providers lack the appropriate resources to serve them. Consequently, most children in this population have experienced multiple placements (some as many as 20) in residential treatment centers (RTCs), psychiatric hospitals, and juvenile detention centers before being placed in a state school.

Figure 1.2 Children in Non-Placement Settings



Source: Texas Department of Family and Protective Services

Yet another indicator of inadequate capacity is the relatively small percentage of foster children who are placed near their home. Unless there is a safety concern or court order to the contrary, CPS will attempt to place children who have been removed as close to home as possible. Doing so minimizes disruptions, allows children to remain in their schools of origin, and makes it easier for their families, caseworkers, attorneys ad litem, and CASA volunteers to interact with them regularly. All too often, however, limited capacity results in placements well outside a child's home community. In these cases, children are often unable to see their siblings or have regular visitation with their parents, and their CASA volunteers face long, costly trips to ensure that they can be in regular contact with the children they represent.

DFPS typically reports the percentage of children that it is able to place in region (approximately 84 percent of all foster children in FY 2007), but this number is somewhat misleading. Texas' 11 health and human services regions are vast—Region 1 alone covers 41 counties in the Texas Panhandle. A better, though admittedly imperfect, indicator of the adequacy of current capacity is the percentage of children placed within their home county (Table 1.1). These numbers illustrate that there is much room for improvement in this area.

The aforementioned trends demonstrate the difficult nature of defining adequate system

capacity. Assessing the additional needs of the foster care system is much more involved than simply counting the number of beds necessary to place every child in care. There are approximately 18,000 children in paid foster care in Texas, but it is not adequate simply to ensure that DFPS and private providers have a total of 18,000 beds somewhere in the state. It would clearly be unacceptable if, for example, each of the18,000 placements were located in two or three regions of the state, or if there were no placements in urban areas. Nor would it serve children well if there were 18,000 placements that served only those with basic level needs. In other words, a placement's location and the type of services it offers are critical variables in the capacity equation.

Table 1.1 Foster Children Placed in Home County

Region	1	2	3	4	5	6	7	8	9	10	11	State
FY 05	26.1%	24.5%	32.5%	23.3%	32.8%	61.6%	23.9%	47.7%	20.8%	90.6%	54.0%	41.0%
FY 06	26.1%	20.0%	30.0%	17.5%	29.6%	61.1%	24.6%	50.1%	17.2%	87.8%	50.0%	40.1%
FY 07	25.2%	20.2%	30.7%	15.7%	31.8%	59.1%	21.2%	48.5%	15.1%	86.9%	45.2%	38.4%
FY 08*	26.7%	19.8%	31.1%	16.2%	28.0%	58.4%	21.9%	49.7%	14.6%	88.5%	44.0%	38.7%

Source: Texas Department of Family and Protective Services

In reality, foster homes and emergency shelters throughout the state have unfilled capacity on the very nights that some foster children find themselves sleeping in offices, hotels, and state institutions. Often, the providers with openings are simply not equipped to serve these children's specific needs, particularly if they display violent behavior, have a significant mental health need, or have a history of running away. Others are unwilling to assume the risk of serving children with intensive needs because they fear that an adverse incident will affect their licensing status.

Ensuring that all children in care have an appropriate placement in or near their community is a daunting task, even when the population remains stable, but years of steady growth in the number of children in care has further exacerbated the capacity problem. Between 2002 and 2007, the number of children in paid foster care grew by about 40 percent, but the capacity of private agency homes and DFPS foster homes only grew by about half that much.† Simply put, the number of foster homes has not increased at nearly the same rate as the number of children needing placements.

Overall growth in the number of children in the state's care has been even more dramatic—77 percent over the same five-year period. Some of this growth has been accommodated by an increasing reliance on non-foster placements, such as relative and in-home placements. Overall, the proportion of children in the state's legal responsibility that is served in a non-foster placement has risen dramatically over the past several years. Despite this trend, however, Figure 1.3 illustrates the continued need for growth in foster placements to serve a portion of the state's growing child population for whom safety considerations won't permit in-home or relative placement.

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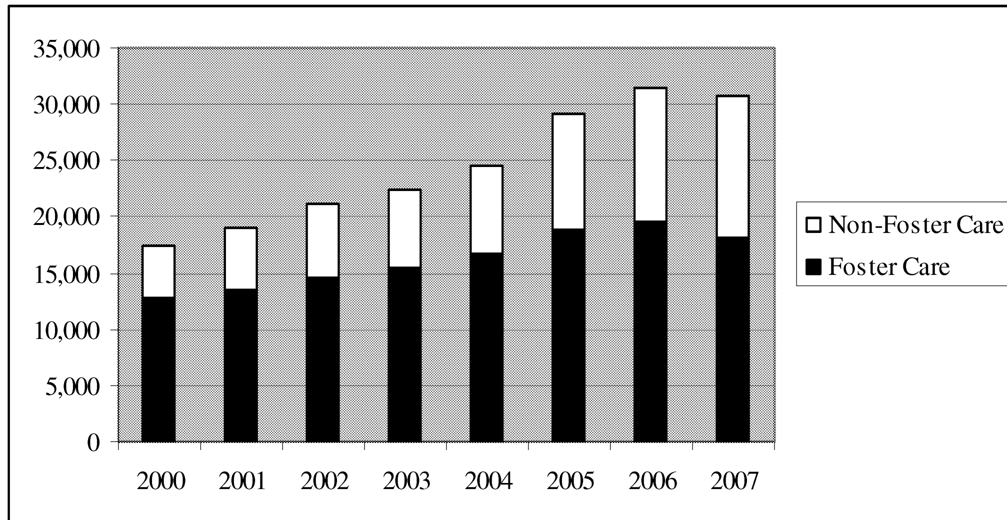
* Percentage reflects the first quarter of FY 2008.

† DFPS data show that children in paid foster care grew from approximately 13,000 to 18,000 children between 2002 and 2007. DFPS and private foster home capacity grew from 29,000 to 35,000 over that same period. Residential operation capacity remained stable.

Figure 1.3 Children in DFPS Legal Responsibility by Living Arrangement



Source: Texas Department of Family and Protective Services

4.1.1 Barriers to Building Capacity

DFPS has employed several strategies to improve foster care capacity for children who are more challenging to serve. For example, in August 2007, DFPS released an emergency procurement to 99 providers in an attempt to increase capacity for children with complex service needs. Only one provider responded, and the procurement was ultimately unsuccessful. Although DFPS is currently in the process of conducting a statewide capacity needs assessment, the results of which will be available in December 2008, stakeholder input provides insight into some of the underlying causes for this specific failure and for inadequate foster capacity in general, including inadequate reimbursement rates, service level system changes, newly implemented minimum licensing standards, and a lack of effective communication between private providers and regional CPS offices.

4.1.1.1 Reimbursement

Providers have noted that reimbursement rates are inadequate at the moderate, specialized, and intense service levels, particularly in light of the regulatory risk to which a provider is exposed when contracting to serve a child with complex behavioral needs. These providers note that the rate increase approved by the Legislature in 2007 does not cover the fiscal impact of newly introduced minimum standards that went into effect that same year.

Table 1.2 illustrates that reimbursement rates actually declined between 2003 and 2006, only rising above 2003 levels by about 1.4 percent in 2008. When those rates are adjusted for inflation, the trend is pronounced; the average daily foster rate in 2008 has 15 percent less purchasing power than it did in 2003. Even without the implementation of more rigorous standards, this decline in reimbursement rates could easily exacerbate capacity problems.

Table 1.2 Weighted Average Foster Care Rate

	Average Daily Rate	% Change from 2003	Average Daily Rate in 2003 Dollars	% Real Change from 2003
2003	$57.99	0.0%	$57.99	0.0%
2004	$55.82	-3.7%	$54.37	-6.2%
2005	$53.91	-7.0%	$50.79	-12.4%
2006	$54.14	-6.6%	$49.41	-14.8%
2007	$54.64	-5.8%	$48.49	-16.4%
2008	$58.80	1.4%	$49.19	-15.2%

Source: Texas Department of Family and Protective Services and the U.S. Bureau of Labor Statistics

4.1.1.2 Service Level System Changes

DFPS contracts with Youth for Tomorrow (YFT) to establish a child's authorized service level based on his or her service needs. YFT staff review information provided by a child's CPS caseworker regarding social, behavioral, medical, and educational history to determine the child's level of need (Appendix C), which in turn determines the daily reimbursement rate a provider receives to care for that child.

In September 2003, DFPS collapsed the six-tiered service level system, creating the system in place today and its four levels of service: basic, moderate, specialized, and intense. As a result of the way the levels were combined and the funding provided by the Legislature, providers saw their reimbursement rates drop for children who had previously been at service levels two, three, five, and six, and for a portion of the children previously assigned to service level four. Provider feedback indicates that these changes have made it more difficult financially for them to serve children with more intensive needs.

4.1.1.3 Minimum Standards

In January 2007, DFPS implemented more rigorous minimum standards of care, including more demanding child-to-caregiver ratio requirements, to improve safety and accountability for children in care. The agency began enforcing these new standards in July 2007. As a result of new standards, foster homes have reported difficulty adapting to and covering the cost of care, and some have elected to cease providing services entirely. While child safety is certainly of utmost concern, it is important to realize that inadequate capacity also has an impact on safety. If the new minimum standards are overly burdensome and thus contribute to capacity challenges, they may, in fact, be counterproductive.

Additionally, some providers have submitted complaints regarding the enforcement of minimum standards. Stakeholders report significant policy inconsistencies among regions and offices, difficulty communicating and working with CCL investigators, and inequitable application of licensing standards between CPS and CPA (private) homes.

4.1.1.4 Local Collaboration

The number of CPS foster homes has declined over the past decade, while substantial growth has occurred among non-profit and other private providers. This trend will likely continue, and future capacity-building efforts will rely heavily, and perhaps exclusively,

on expansions within the private sector. Developing adequate and appropriate placements requires a great deal of collaboration at the local level, yet providers across the state report that productive dialogue with CPS is not taking place in their communities. Effective communication will require a willingness on both sides (public and private) to come to the table in a productive, cooperative fashion, as each plays a critical role in the child welfare system. Without an open and honest dialogue between CPS and providers, future capacity-building efforts will not succeed.

4.2 System Instability

In addition to developing an adequate number of appropriate placements, DFPS is tasked with ensuring that those placements are successful and provide continuity for the children in its care. Casey Family Programs' Northwest Foster Care Alumni Study demonstrates the importance of minimizing the number of placements a child experiences; children who experience fewer placements, shorter stays in care, and no failed reunifications report significantly better education and mental health outcomes.[10]

Inadequate capacity can certainly lead to inappropriate and unstable placements (as described in the preceding section), but other factors contribute to instability in the child welfare system, including workforce turnover, unsuccessful kinship placements, a lack of consistent adult mentorship, inadequate needs assessments, and difficulty coordinating with schools.

<u>4.2.1 Caseworker Turnover</u>

The CVS caseworker takes over after investigation has confirmed abuse and/or neglect. He or she plays a critical role in a foster child's life as the person responsible for assessing needs, making placement recommendations, visiting with the child and his/her family, preparing court reports, attending all court hearings, and communicating with the child's CASA and attorney ad litem.

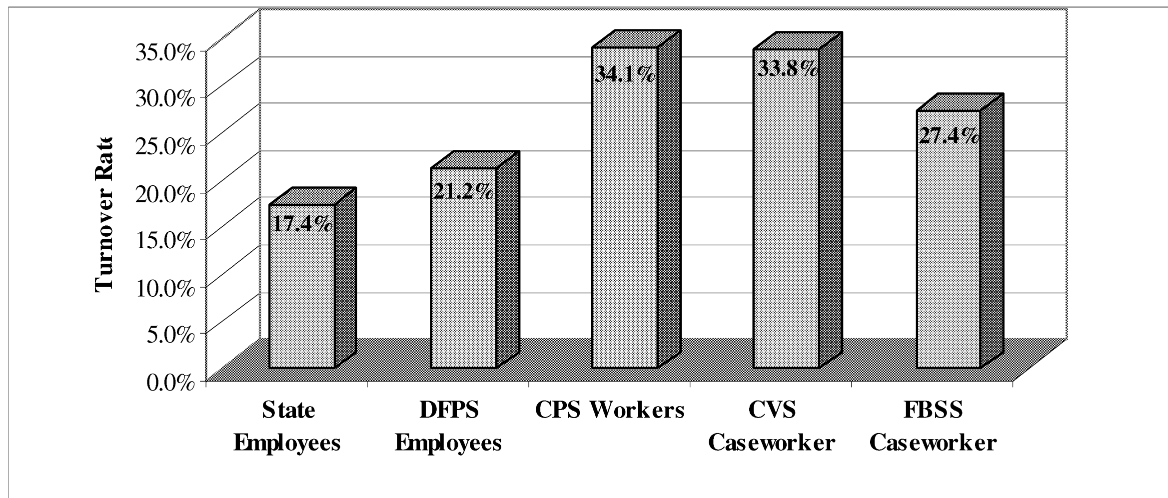
The frequency and quality of caseworker involvement in a family's life influences outcomes for children and families, and caseworker turnover, particularly among CVS caseworkers, has a detrimental impact on children in the custody of the state.[11] A recent study found that 75 percent of children who had only one caseworker during their time in state custody ultimately achieve permanency, compared to 18 percent of those with two caseworkers and less than 1 percent of those assigned six or more caseworkers.[12]

In FY 2007, turnover among state employees across all agencies was approximately 17 percent.[13] Among CPS workers, however, turnover rates were double the state average at 34 percent (Figure 1.4).[14] A number of factors, including workload, compensation, and job preparation affect the agency's ability to retain workers. What's more, many of these factors are interrelated, and problems in one area can exacerbate those in another.

DFPS has paid particular attention to the impact of efforts to reduce caseloads in Bexar County, where performance has typically lagged behind the rest of the state. A recent report indicates that reduced caseloads have been accompanied in Bexar County by measurable improvement in a number of areas. Investigation times have decreased, while

the percentage of children placed with relatives has increased. In June 2006, only 64 percent of monthly visits with children occurred; by June 2008, that number had increased to 87 percent. Adoptions have increased by almost one third, and caseworker turnover has decreased from 47.5 to 30.4 percent. In other words, sustained investment in the system is yielding positive results.

Figure 1.4 Turnover by Job Classification FY 2007



Source: Texas Department of Family and Protective Services & the Texas State Auditor's Office

4.2.1.1 Workload

According to exit interviews conducted by DFPS, excessive workload is the primary cause of high turnover rates among CPS caseworkers. In cyclical fashion, high caseloads drive high turnover rates, leading to perpetual vacancies. In turn, these vacancies increase caseloads for the workers who remain, making them less likely to stay.

The average daily caseload for a CVS caseworker in FY 2007 was 43,[15] more than twice the national average and nearly three times the CVS caseload recommended by the Child Welfare League of America.[16] As a result, CVS caseworkers often have a larger workload than they can reasonably be expected to handle. In fact, preliminary data from the second round of the CFSR indicate that CVS caseworkers in Harris County are only able to meet federal requirements for monthly visitation 74 percent of the time for children and 19 percent of the time for parents on their caseload.

4.2.1.2 Compensation

According to the DFPS exit interview, inadequate pay is the second leading cause for voluntary separation of CPS caseworkers. In FY 2005-2006, the average annual salary for CPS caseworkers, was approximately $30,000, which ranks Texas 48th in terms of caseworker compensation.[17] What's more, evidence suggests that, in areas where salary differentials between CPS caseworkers and teachers are highest, CPS turnover rates are above average.[18] These data support a rather intuitive hypothesis: that caseworkers are more likely to leave CPS to work for the local school district in areas where teacher salaries are significantly better than those provided to CPS workers.

4.2.1.3 Supervision
Poor supervision quality ranks third among reasons that CPS workers choose to quit their jobs, and the relationship between supervision quality and turnover rates is also circular in nature. Reduced tenure among CPS staff is one of the many consequences of high turnover rates, which has an impact on the experience and ability of supervisors to provide quality oversight for caseworkers.

4.2.1.4 Preparation
Fourth among leading causes for caseworkers who leave employment with CPS is inadequate preparation for the job. This may be related in part to on-the-job training, but it is also strongly correlated with an individual's academic background. In one study of the retention of child welfare caseworkers, retention rates were 67 percent among caseworkers with social work degrees, compared to 46 percent among those with backgrounds in psychology or education and only 37 percent among those with other degrees.[19] Another study of CPS retention rates in particular demonstrated that caseworkers with social work degrees were less likely to leave the agency than those with other degrees.[20]

Currently, Texas accepts any four-year bachelor's degree as the prerequisite academic requirement for hire as a caseworker. At least sixteen states require a degree related to the field of social work, while at least three (California, Kansas, and North Dakota) require their caseworkers to have a bachelor's degree in social work. In the District of Columbia, caseworkers must have a master's degree in social work.[21]

4.2.2 Kinship Supports
Kinship care is often preferable to foster care because it can be less disruptive for children who have been removed from the home and is more likely to lead to a permanent placement in cases where reunification with the parent(s) is not possible. Pursuant to legislative direction provided by SB 6, CPS should make every effort to identify and locate a relative or kinship caregiver for a child when he or she has been removed from the home. As a result, CPS' reliance on kinship placements has grown substantially in recent years (Table 1.3).

Table 1.3 Growth in Kinship Placements

	Number of Children in Substitute Care	Number of Children in Relative Placement	Percent of Children in Relative Placement
End of FY 2003	22,346	3,850	17.2%
End of FY 2004	23,051	4,516	19.6%
End of FY 2005	27,059	6,423	23.7%
End of FY 2006	29,232	8,138	27.8%
End of FY 2007	28,339	8,775	30.9%

Source: Texas Department of Family and Protective Services

The Kinship Program provides support to kinship caregivers, which may include training and support, case management services, information and referral, counseling, child care, and limited financial assistance. Eligible caregivers may receive a one-time, $1,000

integration payment per sibling group, as well as annual compensation of $500 to assist with the child's care. In FY 2007, approximately 3,000 kinship caregivers received $5.1 million in financial support to serve nearly 6,000 children in the CPS system. Kinship support is funded through a combination of Temporary Assistance for Needy Families (TANF) block grant dollars and general revenue (GR), as Title IV-E funding cannot be used for subsidized guardianship under current federal law.

The recent emphasis on strengthening kinship caregiver support is certainly positive, but kinship caregivers receive far less financial assistance, preparation, and training than foster care providers. As a result, promoting increased kinship placements without additional financial and other support services presents a challenge, and there may be a limit to which the state can rely on kinship care to ease capacity constraints without additional investment.

SB 723 (80R) directed DFPS to record instances where a kinship placement was not made because the caregiver lacked adequate financial resources. In August 2008, DFPS issued a preliminary report. There were 63 documented prospective kinship placements in FY 2008 that did not occur. In 17 of these cases, the primary reason the individual(s) refused placement was financial. When asked what additional financial support would be required to support the placement, these individuals provided answers ranging from $300 to $1,000 per month.

Because federal dollars cannot be used for subsidized guardianship, additional kinship support funding must be allocated from GR. The federal Fostering Connections to Success and Increasing Adoptions Act of 2008 was passed by the U.S. Congress and signed by the President in October 2008. Significantly, this bill authorizes the use of Title IV-E funding for guardianship assistance payments until the age of 21 for children in kinship placements. If Texas opts to take advantage of this provision, the state will be able to develop more robust supports for qualified kinship caregivers without relying exclusively on state GR. What's more, this legislation increases adoption incentive amounts for children with special needs and delinks eligibility for these payments from the former Aid to Families with Dependent Children (AFDC) program. As a result, all children with special needs will be eligible for adoption assistance.

4.2.3 Frequency and Adequacy of Assessment

Placement breakdown stemming from inadequate front-end assessment is also an issue in paid foster care. Some providers express concern that children are placed too quickly, without adequate information regarding a child’s specific needs. On the one hand, it is important to find stable placements for children as quickly as possible. Consequently, CFSR metrics emphasize rapid placement by categorizing any continuous stay of longer than seven days after removal as a placement for the purposes of federal review. On the other hand, if children are entering inappropriate placements at higher rates because their needs have been improperly assessed, the move to place children quickly may lead to greater instability and poorer performance on the CFSR. In other words, it is important to strike an appropriate balance between assessing children's needs thoroughly and moving them quickly into a permanent placement.

The need for appropriate assessment becomes more pronounced as the acuity level of children in foster care rises. CPS' successful efforts to keep children at home or place them with relatives whenever possible means that children entering the foster care system are often older and more severely traumatized than children traditionally served by providers of substitute care. In fact, it has been estimated that more than 80 percent of foster children have medical, emotional, behavioral, and/or developmental conditions.[22] It is critical that service needs be identified and assessed before a child with moderate to high acuity level is placed. Otherwise, children may not receive necessary services, causing behaviors to escalate into unmanageable problems for their caregivers.

Additionally, once a child has been assessed, there is some concern that his or her level of care is re-determined too frequently, resulting in movement among providers based on assessed acuity. YFT, the vendor responsible for assessing needs and authorizing service levels, is required to re-assess children at the specialized and intense service levels every three months. If a child has intense needs at one assessment, the highly specialized services he or she is eligible to receive may stabilize that child enough that his or her service level is downgraded in three months. As a result, the child is often required to move to another placement, which may mitigate the positive effects of the intensive services he or she initially received.

4.2.4 Adequacy of Advocacy

Having just one consistent and caring adult presence can make a dramatic difference in a child's life—even in situations where a child has multiple placements and/or caseworkers. For many Texas foster children, their CASA plays this important role. Research demonstrates that children with a CASA volunteer experience fewer placements, are more likely to be adopted, and are less likely to end up in permanent foster care than their peers who are not represented by a CASA.[23] In FY 2007, however, Texas CASA was only able to serve about half of children in DFPS custody. For many of these children, particularly for those who have multiple caseworkers, the lack of a single individual who is responsible for following their needs over time results in fragmented and/or inadequate services.

Judges in Texas have substantial discretion in determining to what extent to partner with and benefit from their local CASA programs. Most judges appoint CASA volunteers, when available, as guardians ad litem. CASAs are able to spend substantially more time getting to know a child and his or her situation than attorneys or caseworkers, generally have a caseload of one child or one sibling group, and provide a valuable resource to the court.

Some judges, however, do not take full advantage of their local CASA programs and instead allow the attorney ad litem to play a dual role. This can lead to conflicts of interest, particularly with older children. Attorneys are asked to represent the child's wishes, while guardians ad litem are tasked with representing the child's best interest. As anyone who has raised a teenager understands, the two are often in conflict, and asking the same individual to represent both can be problematic. When conflicts do arise,

attorneys can request the appointment of a separate guardian ad litem, usually another county attorney. In these cases, the decision not to use a CASA as a guardian ad litem doubly strains the county's resources and limits the CASA's ability to share his or her unique insight in an official capacity.

4.2.5 Coordination with Schools

When foster children are required to change schools frequently, they quickly fall behind their classmates and are often required to repeat classes or meet different requirements at their new school. Understandably, many of these children become frustrated with this lack of coordination and simply drop out of school, and frequent moves are particularly problematic for children who qualify for special education services.

In response to this risk, state and federal statute include some limited provisions to promote school stability among foster children. Texas Education Code §25.001(g) requires school districts to allow foster youth attending high school to remain in their school of origin, even if they move outside its attendance zone. The school, however, is not held responsible for providing transportation. The federal McKinney-Vento Act requires that school districts provide transportation for homeless children, including foster children who are waiting for placement, to attend their school of origin.

Children who are not covered by these federal and state laws, or who lack access to transportation, may be required to change schools frequently, and different school districts have different course offerings, diploma requirements, and graduation plans. Coordination between CPS and schools is critical to ensure that the educational needs of foster children are being met, and this is no small task in Texas, where more than 1,100 independent and consolidated school districts operate with significant autonomy. To provide just one example, recent legislation directing school districts to implement a school-based safety identification system for school visitors has resulted in varying interpretations of identification required by CPS staff.

SB 6 required DFPS to create an education passport as a consistent record that follows a foster child from placement to placement. Additionally, CPS employs an education specialist in each region who is responsible for working with children with the greatest need, including children in special education and those in alternative placements, to help coordinate their services. Despite positive feedback from the most recent CFSR evaluation, significant challenges remain in standardizing data, ensuring that every child has a complete education passport, and ensuring appropriate services, particularly for children and youth with disabilities.

4.3 Children in Long-Term Foster Care

After a child's final permanency hearing, he or she may be returned home or placed in PMC, in which case DFPS is granted the authority to make decisions in the best interest of the child on a permanent basis. Generally, a judge terminates parental rights simultaneously, and the child becomes eligible for adoption if that is part of his/her permanency plan. In some cases, however, children are placed in PMC without termination of one or both parents' rights, limiting the child's permanency options to

either relative placement or long-term foster care. This is currently the case for more than 4,000 children in Texas—approximately 14 percent of all children in the legal responsibility of DFPS. What's more, many of these children are very young (Table 1.4). If there are no relative placement options, the child must remain in long-term foster care until he or she ages out of care at the age of 18.

Table 1.4 Children in PMC without Termination of Parental Rights, June 2008

Age	Number of Children
0-5	628
6-11	963
12-17	2,844
Total	*4,435*

Source: Texas Department of Family and Protective Services

The CFSR and, more recently, the Texas Supreme Court's Permanent Judicial Commission on Children, Youth, and Families, expressed concern regarding the outcomes of the large number of children in PMC without termination of parental rights. Oversight of a PMC case is much less thorough than that of a child in TMC. The judge typically sees children in PMC only twice a year, and the child's attorney and CASA are routinely dismissed after the final permanency hearing. As previously described, CVS caseworkers are often overwhelmed, and high turnover means that many of these children will have numerous caseworkers during their time in foster care.

A judge may not feel that he or she has the legal grounds to terminate parental rights for legitimate legal reasons. In some cases, overburdened county attorneys and CPS caseworkers have been unable to make a solid case for termination, even in cases where the child's safety would be jeopardized if he or she were returned home. It is important to understand, however, that many of these children simply remain in the foster system until they age out of care. Consequently, this population has unique needs that should be addressed separately from those children for whom parental rights have been terminated, and every effort should be made to find relatives or other guardians who can provide a stable, permanent home.

5. Conclusion and Recommendations

Barriers to achieving stability and permanency for children in the foster care system are numerous, but addressing them quickly, effectively, and adequately is the surest way to improve outcomes for children and families involved in the CPS system. Building on the work of previous legislatures, the leadership of the Texas Supreme Court, feedback from the CFSR process, and testimony provided by DFPS, stakeholders, and the public, the House Committee on Human Services makes the following recommendations:

1. **Require DFPS to analyze and address inadequate system capacity, particularly for children with complex needs. This review should include the following components:**

    a. Evaluate the impact of minimum standards on capacity (and modify accordingly) to eliminate unnecessary disincentives for CPAs to serve children with high-level needs;

    b. Consider the fiscal impact of newly implemented minimum standards, and determine whether there are low-risk violations with a disproportionately high cost;

    c. Analyze the effect of compressing levels of care on reimbursement rates, focusing specifically on reimbursement for children at or above the moderate service level, and make changes as appropriate;

    d. Promote collaboration with providers and other stakeholders at the local level to build foster and adoptive capacity;

    e. Explore the potential impact of a limited no-reject/no-eject clause on placement stability for children with high-level needs;

    f. Report regularly to the appropriate legislative committees regarding:

        i. the number and percentage of children placed outside their county of origin;

        ii. the number of children placed in an alternative setting (e.g., CPS office) or state institution;

        iii. the number of children waiting for adoption; and

        iv. the average (mean, median, and mode) number of placements for children in the state's care by conservatorship status and level of care.

2. **Pursuant to the completion of the aforementioned analysis, DFPS should implement any necessary changes, in addition to:**

a. Targeting capacity-building efforts to counties with relatively large numbers in foster care and the highest rates of out-of-county placement; and

b. Focusing all future capacity-building efforts on the private sector, including non-profit, community-based, and faith-based agencies.

3. Authorize funding and implement policies to address the negative impact of high CVS caseloads and workforce turnover to restore balance between investigative and conservatorship units:

a. Implement a hire-ahead strategy to minimize the impact of turnover on caseload levels;

b. Reduce CVS caseloads to levels that will allow compliance with CFSR standards;*

c. Implement and fully fund the case management pilot authorized by SB 758 (80R). Statewide changes should not be made based on the pilot's results unless a comparable control in the public sector is also funded and evaluated independently by a third-party;

d. Maximize employ of stipend social workers as caseworkers; and

e. Monitor incentives provided in other states to improve workforce retention and recruitment through education reimbursement and other strategies, particularly with regard to cost benefit data.

4. Support the efforts of Texas CASA to provide a CASA volunteer for every child, and mitigate the effects of recent federal funding cuts to CASA programs by:

a. Promoting public awareness regarding the role and importance of CASA programs; and

b. Providing an additional $3 million in FY 2010 and $4.8 million in 2011 in GR for local CASA programs to recruit and train additional volunteers, subject to Texas CASA meeting and reporting target performance objectives.

5. Consider requiring family court judges who do not currently appoint CASA volunteers, when available, as guardians ad litem to take advantage of this

* In its Legislative Appropriations Request for the 2010-11 biennium, DFPS is requesting $21.2 million GR to hire an additional 241 FTEs so that it can meet the CFSR requirement that 95 percent of children and families receive monthly face-to-face visits from their caseworker.

valuable resource that comes at no cost to the county. Allowing CASAs to have a voice in every court room in the state should be a priority.

6. **Improve placement stability for children in care by:**

   a. Implementing a pilot program to examine the impact of more comprehensive pre-placement assessments for children with intensive needs on placement breakdowns;

   b. Instituting a consistent 12-month level re-evaluation period for children in foster care, regardless of level of need; and

   c. Drawing down newly authorized federal funding to increase assistance payments to relative caregivers with PMC with the goal of strengthening kinship placements and curtailing the number of children entering foster care.

7. **Promote educational stability for foster children by:**

   a. Improving data sharing and collaboration between the Texas Education Agency (TEA) and DFPS;

   b. Improving coordination between regional education and disability specialists for children in special education;

   c. Prioritizing the placement of children so that they may continue to attend their school of origin; and

   d. Making education portfolios electronic.

8. **Address the needs of children in PMC without termination of parental rights and ensure that long-term foster care is never a child's permanency plan by:**

   a. Improving efforts to locate and work with absent parents and potential relative caregivers;

   b. Studying the impact of denying relative care based on remote criminal histories;

   c. Providing additional funding to counties for the purpose of allowing children in PMC to have access to an attorney and/or guardian ad litem after their final permanency hearing.

9. **Increase the likelihood that adoptions will be consummated and that the valuable resource of the state's foster/adoptive families is preserved by improving communication with foster/adoptive families that have expressed**

interest in adopting a child who is placed in their care.

a. In every case, this should include notification of the existence of possible relative or other caregivers; and

b. Notification of the possibility that a child may be placed with a relative or other caregiver rather than becoming eligible for adoption.

10. **Consider extending Medicaid eligibility to the age of 21 for children adopted from the child welfare system who maintain eligibility through the age of 18, as would be the case had they remained in the system.**

a. Many foster/adoptive families do not have the resources to provide private health coverage for the children they adopt, particularly in cases where these children have significant physical and behavioral health needs; and

b. Extending Medicaid eligibility would remove a disincentive to adopting children with more intensive needs.

6. Testimony and Public Comment

The House Committee on Human Services heard testimony on its first interim charge at two separate hearings (February 21, 2008, at the University of Texas at Arlington and April 3, 2008, at the Texas State Capitol in Austin). Testimony was provided by DFPS, stakeholder groups, and the public at large. This section summarizes public and written testimony received by the committee relating to promoting permanency and stability for children and families involved in the child welfare system.

6.1 Department of Family and Protective Services

On February 21, Joyce James, Assistant Commissioner of CPS, provided testimony regarding capacity, efforts to increase adoptions, and workforce issues. Additionally, Ms. James provided information specific to the children in care in Region 3.

6.1.1 Capacity

The number of children in DFPS care in Region 3 and throughout the state has declined over the past year. Fewer children have been placed in all settings, including CPA and DFPS foster homes, residential treatment centers, and emergency shelters. DFPS is currently unable to determine the underlying cause for the decreasing number of children in care.

Despite a reduction in the DFPS population, some children remain difficult to place. Specifically, two children in Region 3 lacked placements during each of the past three months (November 2007 - January 2008), down from a high of 41 in June 2007. In Region 3, 15 percent of children were placed outside the region, indicating an inadequate number of appropriate placements to serve all children. Follow-up documents after Ms. Joyce's testimony show that, across the state, 16.8 percent of children are placed outside of their home region, and 61.3 percent are placed outside their home county.

DFPS is working in several ways to address the problem of inadequate capacity. First, it is conducting a statewide needs assessment to be published with recommendations in fall 2008. Second, it is working to target capacity increases to the areas of the state with the largest unmet need and for the levels of care that are in greatest demand. Third, DFPS is working with Casey Family Programs to enhance internal efficiencies through an analysis of its business processes.

6.1.2 Adoptions

DFPS has substantially increased the number of consummated adoptions in Texas over the past three years, from 3,173 in FY 2005 to 4,023 in FY 2007. However, at the end of August 2007, 679 children in Region 3 and 4,375 children statewide were waiting for adoption, compared to 568 in Region 3 and 2,980 statewide at the end of FY 2005. According to Ms. James, many of these children face barriers to adoption (Table 1.5). Some are in large sibling groups, many are older and have been in the system for greater lengths of time, and others have special needs. As is the case with children in DFPS care, African-American children are disproportionately represented among those waiting for adoption.

Table 1.5 Children Waiting for Adoption, FY 2007

Total Children Waiting For Adoption	4,375
Gender	
Female	2,017
Male	2,358
Age Groups	
Birth - 2 yrs	766
3 - 5 yrs	802
6 - 9 yrs	1,072
10 - 13 yrs	1,114
14 - 17 yrs	621
Race/Ethnicity	
African American	1,350
Anglo	1,120
Asian	10
Hispanic	1,810
Native American	4
Other	81
Level of Care	
Basic	2,124
Moderate	1,084
Specialized	749
Intensive	62
None	356
Disabling Conditions*	
Developmental Disabled Diagnosed	140
Drug/Alcohol	509
Emotional	1,346
Learning	1,235
Medical	399
Physical	80
* - The count of children includes duplicates because a child may have more than one disabling condition.	

Source: Texas Department of Family and Protective Services

Ms. James attributed the increase in the number of consummated adoptions to heightened public awareness and increased efforts to promote adoption at the state and local levels. On National Adoption Day in November 2007, 221 adoptions were consummated across the state. Heart Galleries and the One Church One Child initiative have worked to recruit foster and adoptive families. Results from local collaboration between CPS and CPAs have been promising. Additionally, as a result of SB 640 (80R), which passed during the 80th Legislative Session, the state will hold its first "Texas Adoption Day" in 2008.

6.1.3 Workforce
CPS caseworker turnover continues to present a barrier to supporting permanent, stable placements for children in the state's care, with more than one third of all caseworkers leaving their positions during FY 2007.

DFPS employs three categories of caseworkers. Investigative caseworkers (INV) are assigned to investigate allegations of abuse and neglect. CVS caseworkers are responsible for monitoring the care of children who have been removed from the home and are in the conservatorship of CPS. FBSS caseworkers are assigned to families involved in the CPS system but whose children are being maintained at home. As a result of legislative action in 2005, INV caseloads have dropped significantly, from 41.1 in FY 2005 to 25.3 in FY 2007. CVS and FBSS caseloads, however, have increased. What's more, responsibilities associated with a case have also increased over this same period.

6.2 Texas CASA
On February 21, Andrea Sparks, Program Expansion Specialist, explained that CASA programs throughout the state are able to serve approximately 20,000 children with 5,000 volunteers, but this number represents only about 50 percent of the number of children who come into care during a year. Texas CASA is pursuing statewide initiatives to raise awareness and increase the number of CASA volunteers in the state.

CASA volunteers from Region 3 presented their experiences and concerns to the committee, pointing out a number of gaps in the current system and citing the following barriers to permanency:

- Some children experience multiple failed placements, often related to behavioral issues at home or in school;
- Children are occasionally separated from their siblings;
- Many children have multiple CVS caseworkers while in care;
- Many foster children are behind in school, due in large part to placement instability;
- Placements outside a child's region pose significant problems for the child, caseworker, and CASA volunteer; and
- In many cases, attorneys ad litem are overwhelmed and do not spend adequate time with children.

On April 3, Joe Gagen, Chief Executive Officer for Texas CASA, provided additional testimony regarding the role of CASA in Texas' child welfare system. Mr. Gagen indicated that the state currently funds approximately 10 percent of the operational costs for CASA statewide. Inflationary pressures, particularly with regard to transportation, as well as donor base competition and an expected 25 percent cut in federal grants have placed additional financial pressures on local CASA programs. Texas CASA aims to provide a CASA volunteer to represent every child in foster care, which represents a good investment from the state's perspective. The state is required to appoint a guardian ad litem to every child in TMC, and CASA volunteers fulfill this role at no cost to the

state. What's more, if there were more CASA volunteers, children in PMC could also benefit.

Laura Wolf, Executive Director, and Key Richardson, Program Director, provided testimony on behalf of Travis County CASA. This CASA program recruits an estimated 130 new volunteers every year, provides extensive training and screening, and serves almost 800 children in Travis County. With support from a local CASA volunteer, Ms. Richardson and Ms. Wolf described the regular advocacy provided by a CASA, as well as the logistical and financial difficulties that arise when children are placed outside of their home county or region.

6.3 Center for Public Policy Priorities

F. Scott McCown, Executive Director, provided testimony to the committee on February 21 relating to the current and projected need for appropriate placements and potential strategies to increase capacity.

Applying recent CPS removal rates to Texas' child population projections, the Center for Public Policy Priorities estimates that the number of children removed from their home will increase from 16,000 in 2007, to 27,000 by 2040. This projected increase will likely exacerbate the current capacity problem. What's more, there is a need for an array of foster homes and treatment centers throughout the state to meet the diverse needs of children who have experienced abuse and neglect. DFPS should analyze current capacity, not only at the regional level, but by county as well.

To address the need for increased capacity, particularly for children with special needs, Judge McCown offered the following recommendations:

- Consider whether licensing standards and regulations are reasonable. While protecting children from harm is critical, more rigorous standards may reduce the supply of foster homes;
- Examine the adequacy of reimbursement rates for foster homes, particularly in light of new minimum standards;
- Investigate the effect of the service level system and whether the consolidation of six levels into four in 2004 has affected capacity, particularly at higher levels of care; and
- Consider the implementation of a no-reject/no-eject clause, with some limitations, in contracts with private providers.

6.4 Permanent Judicial Commission for Children, Youth, and Families

On February 21, Judge John Specia, Vice Chair, and Tina Amberboy, Executive Director, provided background information on the commission's creation and purpose and recommended the following strategies to improve permanency for children in the system:

- Judges represent the front line; no child enters or exits the system without a court order. Training and educating judges and attorneys, particularly regarding

substance abuse, family violence, and mental health, is critical to improving permanency for children;
- The quality of legal representation for children is important, and adequate compensation plays a role;
- The state should do a better job of tracking data to follow children through the system; this could help judges in managing their dockets and informing their placement decisions; and
- The state should increase its level of support for CASA programs to ensure that every child has an advocate.

6.5 Texas Association for the Protection of Children
On February 21, Madeline McClure, Executive Director, addressed the impact of workforce turnover on permanency and stability for children and families and offered recommendations for improving workforce stability.

Turnover in the CPS workforce is significantly higher than that of state employees in other fields. The costs associated with turnover include hard and soft costs, such as administrative time, burden on co-workers, and recruitment and training costs, as well as human costs. Based on estimates provided by the United States Department of Labor, the hard and soft costs combined actually exceed the annual salary of the average caseworker. What's more, caseworker turnover has a detrimental effect on children's permanency outcomes.

Recently administered exit interviews by DFPS indicate seven common factors influencing a caseworker's decision to leave: high caseload; inadequate pay; poor supervision quality; inadequate preparation; lack of recognition; paperwork; and chronic stress. In a cyclical fashion, high turnover rates contribute to caseloads that are well above both the national average and recommended levels, which in turn leads to higher turnover rates.

Ms. McClure offered the following recommendations to combat high turnover rates:

- Because perpetual vacancies lead to high caseloads, DFPS should practice a hire-ahead strategy similar to the one employed in a 2001 pilot program directed by SB 962 (77R). Under this model, DFPS could hire more caseworkers than authorized by the FTE cap in order to "catch up" with vacancies created by turnover;
- Because caseworker retention rates are much higher among those who have appropriate degrees and/or training, DFPS should prioritize hiring caseworkers with social work and related degrees;
- Evidence indicates that CPS turnover rates are higher in areas with greater discrepancies between teacher and caseworker salaries. Offering competitive compensation would boost retention rates by reducing the incentive to leave CPS to work for local school districts; and
- Improving retention will, in turn, have a positive impact on supervisor quality, as experience is a key determinant of supervisory skills.

6.6 East Texas Heart Gallery

On February 21, Denise Grugle, President, stressed the challenges posed by caseloads for CPS caseworkers. Ms. Grugle also recommended that the state examine the causes of adoption disruption and that better collaboration be fostered between public and private providers.

6.7 University of Houston

Professor Patrick Leung, Co-Chair of the Texas Title IV-E Roundtable Evaluation Committee and University of Houston professor, testified on February 21 to the importance of child welfare training on child outcomes. Prof. Leung cited studies demonstrating that stipend program graduates are more prepared to enter the field of child welfare, have better retention rates, are more confident in their abilities, and demonstrate more competence in their knowledge, skills, and coping abilities. Based on his research, stipend social workers produce significantly better outcomes in the following areas: recurrence of maltreatment; incidence of abuse/neglect in care; placement stability; length of time to reunification; and length of time to adoption.

6.8 Institute of Child Development, Texas Christian University

Dr. Karen Purvis, Director, provided testimony on February 21 regarding her work with children with post-traumatic stress disorder and significant behavioral health needs. She testified that foster families are often unprepared to deal with the high percentage of children in the system who have specialized needs. According to Dr. Purvis, placement breakdowns are often the product of behavior breakdowns, and better training for foster and adoptive families is essential.

6.9 Texas Loves Children, Inc.

Barbara Elias-Perciful, President, serves as an attorney ad litem for abused and neglected children. On February 21, Ms. Perciful described how high caseloads endanger children and have a negative impact on court cases. Caseworkers who are unable to spend an adequate amount of time on a case often fail to notice danger signs in foster homes and after reunification, jeopardizing children's safety. Additionally, without adequate and consistent casework, attorneys lack the information needed to make their legal case and effectively lose evidence and a witness every time a child's caseworker changes.

6.10 Other Public Testimony: February 21, 2008

Numerous professors of social work and former social workers testified in favor of expanding DFPS' use of stipend social workers to recruit more experienced and better prepared caseworkers, improve retention rates, reduce caseloads, and improve supervisor quality.

One social work student described how low pay and high caseloads discourage students from working for CPS.

Several concerned citizens offered support for increasing caseworker compensation to combat chronic turnover and improve outcomes for children.

Several former CPS caseworkers testified to the importance of high-quality, dedicated supervisors and discussed the negative impacts of strenuous work requirements, low pay, and lack of respect for caseworkers.

Lynne McLean, a child welfare board vice chair testified that high turnover rates have a negative impact emotionally on children, slow the permanency process, endanger children, and create a dearth of tenure. Recommendations included reinstating the hire-ahead pilot, reducing caseloads, making caseworker salaries commensurate with those of teachers, and hiring only social workers with a degree in a related field.

6.11 Texas Alliance of Child and Family Services

On April 3, Nancy Holman, Executive Director, emphasized the interrelated nature of many of the barriers to stability, permanency, and adoption. Ms. Holman offered the following recommendations to address the committee's first charge:

- Texas continues to struggle with developing a case management structure that provides continuity of care to the children and families affected by abuse and neglect. The state should consider a new model for how best to operate and manage the CPS program, with emphasis on the San Antonio area where caseworker turnover is exceptionally high;
- The state should fully fund the cost of care. The cost of providing residential and adoption services far exceeds current reimbursement rates, and increased minimum standards added an estimated $37 million to this cost. As a result, DFPS is often forced to negotiate child-specific rates to find placements for children with high-level needs, and the state misses opportunities to increase the number of adoptive families by failing to appropriate additional funds for adoptions in the private sector; and
- To build capacity, the state must effectively balance risk and safety concerns. Regulations and licensing provisions should be assessed and revised in light of capacity needs, and the impact of blending levels of care and frequent level re-assessments should be analyzed.

6.12 Texans Care for Children

On April 3, Susan Craven, Executive Director, underscored the detrimental impact of high CVS caseloads on the safety and well-being of children for whom the state is legally responsible. Ms. Craven cited this factor as the primary cause of system instability and urged DFPS to request funding in its Legislative Appropriations Request to bring caseloads for CVS workers to the national average.

Ms. Craven also expressed support for investing state money to support children in their own homes whenever possible. Particularly in cases where poverty is the primary cause of neglect, housing and other financial supports could go a long way towards preserving families without placing children at risk. Texans Care for Children is highly supportive of DFPS efforts to expand its Family Group Conferencing and Family Group Decision-Making efforts.

Finally, Ms. Craven conveyed strong support for kinship care expansions in Texas. While full subsidized guardianship is costly and must be funded entirely with state GR, a positive first step may be to target a smaller group of children. As an example, children of incarcerated parents may benefit from long-term relative placements without the termination of parental rights, but these families often require financial supports to make the placement work.

6.13 Judge Darlene Byrne

On April 3, Judge Darlene Byrne, presiding judge for Travis County's 126th Judicial District Civil Court, described her role in the child welfare system. All CPS dependency hearings in Travis County pass through her courtroom— approximately 100 cases every month. Currently, Travis County has, on average, 700 active CPS cases and 1,200 children in some type of substitute care.

Judge Byrne provided testimony regarding the role of CASA volunteers in her court, praising the work of the CASA program in Travis County. Judge Byrne described her high expectations for volunteers, including appearing at every hearing for the child they represent and providing written reports. Judge Byrne appoints the CASA as guardian ad litem in every case and believes that they should be cloaked with this official authority. Doing so allows the judge to hear their perspective, which may be at odds with the department and/or attorney, and provides a guardian ad litem at no cost to the county or state.

6.14 Judge Karin Bonicoro

Judge Karin Bonicoro is an associate judge appointed to preside over the Child Protection Court of Central Texas, one of 15 cluster courts across the state that serve rural areas and multi-county jurisdications. Her current caseload consists of approximately 400 children, 250 of whom are in PMC.

In her testimony on April 3, Judge Bonicoro identified the following common problems within her court's jurisdiction:

- Inadequate in-county foster homes result in a child's removal not just from home, but also from school, relatives, churches, neighborhoods, and youth activity leagues;
- Caseloads are crushing, causing turnover and leading to less experienced workers with less ability to assess children's needs;
- State-imposed time limits on cases, while well-intentioned, further increase pressure on caseworkers; and
- Available services are inadequate, particularly in rural counties. When individuals must travel to receive services, DFPS is often unable to meet their transportation needs.

Judge Bonicoro recommended that services be clustered in one location whenever possible, particularly for rural consumers and emphasized the importance of collaboration

among stakeholders at the local level to ensure that pressing problems and available resources are identified.

6.15 Austin Children's Shelter

Gena VanOsselaer, Executive Director, provided testimony on April 3 regarding the importance of adequate assessment to ensure that children are matched with appropriate and stable placements. Ms. VanOsselaer described federal requirements limiting the department's ability to take the time to assess children adequately and recommended the implementation of a pilot program to determine if better assessment at the front end, even if it is considered a placement for the purposes of federal review, can reduce the number of placements in the long run.

Beth Peters, Director of Clinical Programs, underscored that a lack of capacity in group-home placements for children with high-level needs contributes greatly to instability in the current foster system. She described receiving 150 calls per month to accommodate children with intensive needs, even though the shelter is only able to serve 20-30 children. Ms. Peters also recommended that the state take a closer look at the current leveling system and its impact on placement stability.

6.16 Adoptation

Adoptation is a public-private collaborative that works to increase adoptions in the Houston area. Constance Barker, Director of Government Affairs for DePelchin Children's Center, provided testimony on April 3 regarding problems with caseworker turnover and new licensing standards on behalf of Laurie Glaze, Adoptation's Managing Director.

Concerns included the lack of communication between the CPS caseworker and provider, limited caseworker availability to supervise visits, under-prepared and overwhelmed caseworkers, and disengaged CPS supervisors. Additionally, Ms. Barker indicated that fewer and fewer families are willing to open their homes and provide for children in foster care because of strict licensing standards, which would be considered unreasonable in traditional homes.

Ms. Glaze's written testimony provided the following recommendations to the committee:

- Increase the number of children achieving permanency through adoption by funding contract adoption services that enable the private sector to build adoption capacity;
- Develop performance-based contracts that give child placement agencies responsibility for permanency outcomes and incentivize CPAs to place children with complex needs, decrease the amount of time children remain in foster care, and minimize placement changes;
- Explore ways to safely shift funds from foster care to adoption without risking foster care; and
- Develop and implement long-term community partnerships and awareness

campaigns.

6.17 Texas Appleseed

Madison Sloan, Legal Fellow, provided testimony on April 3 regarding foster youth in the Texas Youth Commission (TYC) system. Ms. Sloan pointed out that these children generally have no one to advocate on their behalf to ensure that they receive needed services, that there is a basic lack of information sharing between the two systems, and that there is a lack of consistency regarding the way the CPS case is treated when a child enters the TYC system.

6.18 National Association of Social Workers

On April 3, Carol Miller, Director of Government Relations, provided written testimony and recommendations related to caseworker retention. Ms. Miller's recommendations centered around the qualifications and workload of supervisory staff. She recommended the incorporation of clinical supervision into the supervisor's role and responsibilities, which would require that the supervisor have obtained a degree in social work. Ms. Miller also recommended that supervisors' administrative tasks be reassigned to reduce workload.

6.19 Caring Family Network

Mike Foster, Director of Development, provided written testimony on April 3 to recommend that the state create a continuum of care that addresses the needs of children and families before, during, and after involvement with the child welfare system. Mr. Foster pointed to the challenges of serving older children whom the system has failed. These children have cycled repeatedly through the foster system and require a holistic and therapeutic service model.

6.20 Other Public Testimony: April 3, 2008

Rev. Iman Edwards, a foster/adoptive parent provided testimony regarding the challenge of working with CCL after the implementation of new minimum standards. For example, he and his wife are required to keep behavioral and medical logs on each child, keep electrical outlets covered at all times, and ensure that detergent and knives are locked away. As a result of licensing requirements, the family was recently required either to install a $20,000 sprinkler system or remove one child from their home. Rev. Edwards described the emotional toll that this took on his family as they were ultimately required to send one of their foster children to another home. In addition, he expressed concern that his ability to provide care and prepare children for independent living is hampered by new standards.

Rose Marie Penzerro, a professor and social worker described the phenomenon of foster care drift, on which she has conducted substantial research. Drift is the tendency for some children to move from place to place, occurring more often the longer a child remains in care. Children who experience drift typically come into care later, have special education needs, and display difficult-to-manage behaviors. Dr. Penzerro suggested that the levels of care be analyzed as a contributor to drift, that adoption training be provided to judges, attorneys, and caseworkers, that TEA and DFPS work

together to report to the Legislature on the number of special education students in the foster population, and that children in kinship placements receive more services.

In written testimony, Karen Langsley, a child welfare attorney, addressed several issues related to permanency. First, she pointed out a number of assumptions that, when made with no consideration of the specific situation at hand, may be injurious to children. In Ms. Langsley's experience, children are not always better off with families or siblings, may be served well in a relative or adoptive placement in cases where the caregiver has a very old criminal history, and may not require removal in incidents of domestic violence where the perpetrator has been removed. Second, Ms. Langsely criticized the policy that excludes CPAs as parties to the suit, as they cannot be compelled to act or held in contempt. Finally, she questioned the relatively recent legislative decisions that have adequately funded investigations while leaving conservatorship units under-funded.

Ms. Langley made the following recommendations regarding the committee's first interim charge:

- Implement a policy requiring both the investigator and the Central Placement Unit to check for siblings upon removal of an infant rather than moving that child to a new placement later, thereby risking attachment disorder;
- Examine the philosophy that children are always better with family, particularly in cases where biological family refuses placement initially or did not have placement during the termination proceeding;
- Require careful review of financial resources before making kinship placements;
- Implement waiver systems for situations where the criminal history of a willing caregiver is too old, stale, or irrelevant to be an issue with regard to adoption or placement;
- Require CPAs to be a party to the conservatorship lawsuit; and
- Allow children to remain at home in cases where the child can be protected by excluding the perpetrator from the home.

7. List of Acronyms

ACF	Administration for Children and Families
APS	Adult Protective Services
CAC	Children's Advocacy Center
CASA	Court Appointed Special Advocate
CCL	Child Care Licensing
CFSR	Child and Family Services Review
CPA	Child Placing Agency
CPS	Child Protective Services
CVS	Conservatorship [caseworker]
CWB	Child Welfare Board
DFPS	Department of Family and Protective Services
FBSS	Family-Based Safety Services
GR	General Revenue
HHSC	Health and Human Services Commission
INV	Investigative [caseworker]
JMC	Joint Managing Conservatorship
PEI	Prevention and Early Intervention
PIP	Program Improvement Plan
PMC	Permanent Managing Conservatorship
RTC	Residential Treatment Center
TANF	Temporary Assistance for Needy Families
TCCWB	Texas Council of Child Welfare Boards
TEA	Texas Education Agency
TMC	Temporary Managing Conservatorship
TYC	Texas Youth Commission
YFT	Youth for Tomorrow

8. Notes

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CHARGE 2

Explore strategies to support the needs of aging Texans effectively and efficiently. This investigation should include best practices in delaying or avoiding the need for institutional care as well as promoting high-quality services for those who are best served in nursing homes.

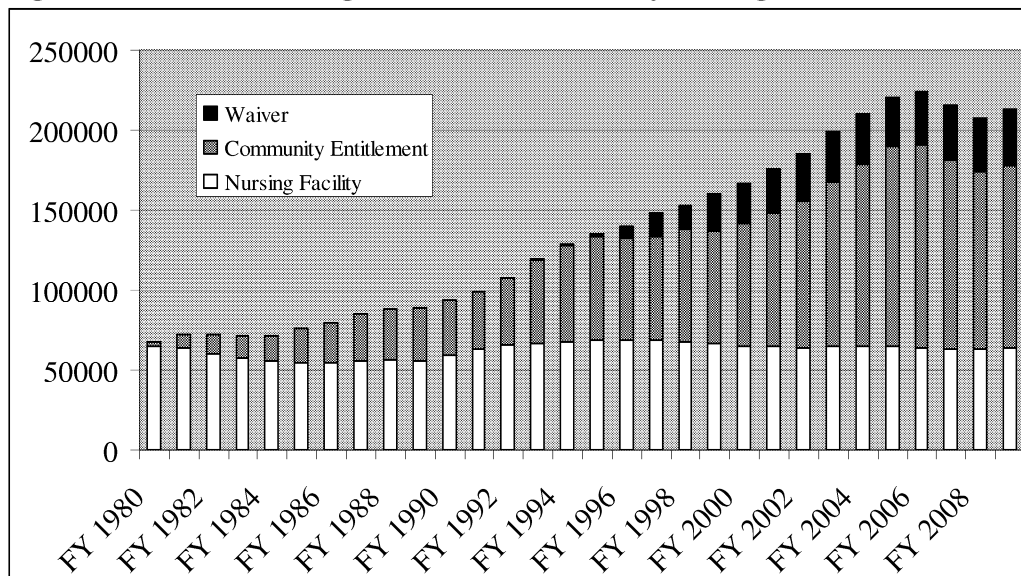
1. Defining Long-Term Care

Long-term care refers to the array of health services provided to persons with chronic illness and/or physical, developmental, or cognitive disabilities, including those who have lost the ability to care for themselves due to age-related disabilities. The type and intensity of long-term care services needed by Texas' elderly population vary greatly. Long-term care can refer to the informal and even intermittent care provided by a spouse, child, or neighbor. It includes services that non-profit and faith-based agencies provide daily to support the elderly who wish to age in place, including home-delivered meals, transportation to the grocery store, or help with home maintenance. More familiarly to many, long-term care services also encompass the formal care available in assisted living facilities (ALFs), as well as intensive services provided by personal care attendants, home health workers, and nursing facility staff.

2. Long-Term Care Trends

The long-term care system should ideally consist of a continuum of services provided in both community and institutional settings, according to an individual's needs and desires. In 1999, the United States Supreme Court affirmed this assertion in its *Olmstead* decision, which requires that persons with disabilities be placed in community settings whenever appropriate care can be provided in that environment, so long as the placement is not opposed by the individual and can be "reasonably accommodated" by the state.[1]

Figure 2.1 Medicaid Long-Term Care Census by Setting



Source: Texas Department of Aging and Disability Services

Even before the *Olmstead* decision, however, many states began to examine the setting in

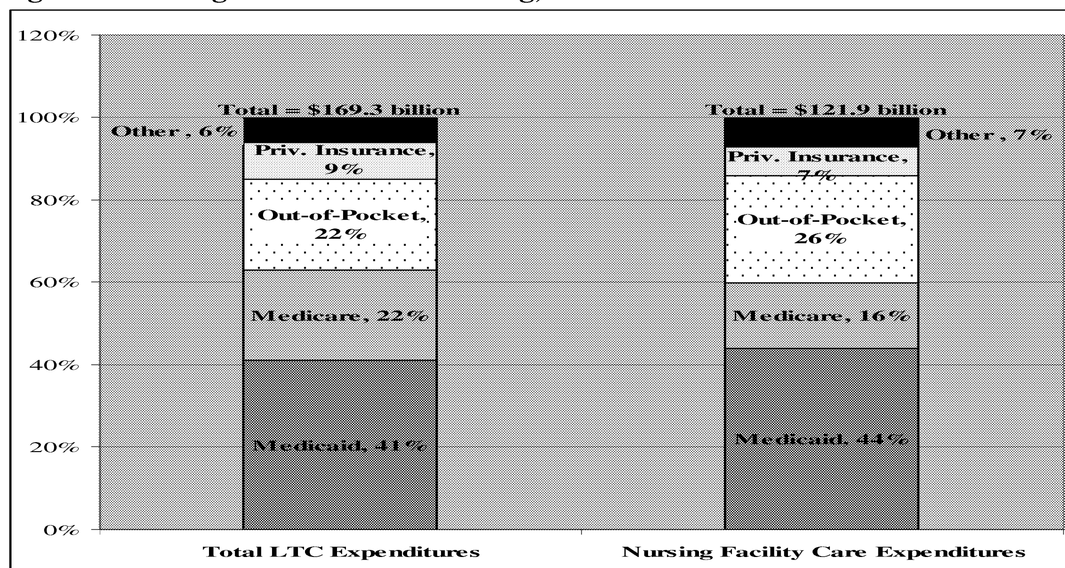
which long-term care services are provided with an eye towards more inclusive and cost-effective means through which to serve the aging and persons with disabilities. Consequently, national trends have shifted in recent decades to favor care provided in home and community-based settings, and the array of services available to aging Texans is generally consistent with this trend. As service delivery systems have become more innovative and individualized, the proportion of the aging population residing in institutional settings has declined, and Texas' nursing home census has remained stable at the same time that the population has increased (Figure 2.1). In other words, nursing facilities have evolved to serve an older and frailer population than in the past, and many individuals who would have been institutionalized in previous decades are now able to access community-based long-term care services, often at a lower cost.

Texas' long-term care system has been relatively innovative with respect to the provision of community-based care for the aging. Texas was one of the first states to include home- and community-based long-term care services in its state Medicaid plan. What's more, Texas' Money Follows the Person (MFP) initiative, which ensures that individuals entitled to receive Medicaid services in a nursing facility can opt instead for community placement, is a nationally recognized strategy. Today, more aging Texans receive Medicaid-funded services in the community than in nursing homes, as the emphasis has shifted to keeping individuals with long-term care needs in their homes and communities whenever possible.

3. Texas' Long-Term Care System

Many people erroneously assume that their long-term care needs will be met through their private health insurance policy, or that Medicare will cover the cost once they are eligible. In fact, Medicare, like the majority of private insurance plans, only covers rehabilitative care for a defined time period, and even many long-term care insurance policies include daily limits and lifetime expenditure caps to curb reimbursements.

Figure 2.2: Long-Term Care Financing, 2005

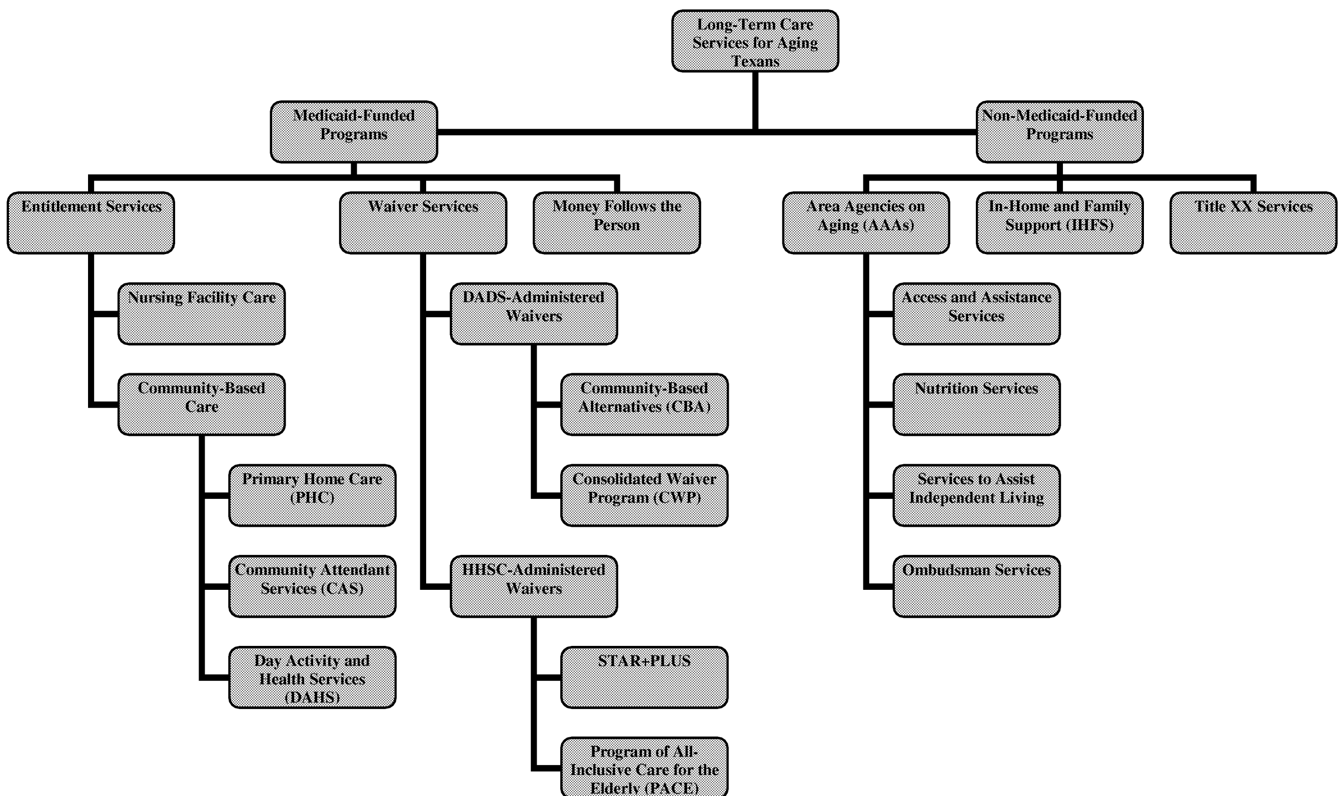


Source: 2007 CMS National Health Accounts data, adapted from the Kaiser Commission[2]

3.1 Eligibility
To qualify for Medicaid-funded long-term care services, an applicant must meet specified financial and functional requirements. More specifically, individuals must meet income and resource limits, which vary by program, and have a physician-documented medical need that either prevents them from performing activities of daily living (ADLs) or requires skilled nursing care.

3.2 Services
The Department of Aging and Disability Services (DADS) and the Health and Human Services Commission (HHSC) administer a number of long-term care programs to serve aging Texans. These include Medicaid-funded, community- and facility-based entitlements, Medicaid 1915(c) waiver programs, the MFP program, services funded through general revenue (GR), Title XX services, and services available through Area Agencies on Aging (AAAs). Figure 2.3 provides a visual representation of long-term care services for the aging population.

Figure 2.3 Publicly Funded Long-Term Care Services for Aging Texans



3.2.1 Entitlements
Persons who meet eligibility guidelines are entitled to receive Medicaid-funded services that are included in the state's federally approved Medicaid plan. In Texas, both community- and facility-based services are included in the state plan, and eligible persons may receive care in either setting, based on their individual needs and choices. This

option makes Texas unique; until the passage of the federal Deficit Reduction Act (DRA) of 2005, Texas was among only a few states in the nation with community-based long-term care entitlement programs. Their inclusion in the state plan has allowed the state, in some cases, to divert individuals with less intensive needs from more costly nursing facility care and serve them in more integrated settings. In FY 2007 alone, more than 100,000 Texans with aging-related and other disabilities were served in a community-based entitlement program.

3.2.1.1 Nursing Facilities

Nursing facilities provide comprehensive, 24-hour care for their residents, including room and board, social services, skilled nursing, medical supplies and equipment, and personal care. While the state has certainly moved many Medicaid-funded long-term care recipients from nursing facilities into community settings, access to nursing home care remains crucial for some of Texas' oldest and frailest residents, an increasing number of whom suffer from Alzheimer's and dementia.[3]

Persons may qualify for care in a nursing facility if they meet the following criteria:

- Their income must fall within 300 percent of the Supplemental Security Income (SSI) eligibility limit (currently $1,911 per month);
- Their countable resources must be less than $2,000;
- A physician must certify that they require 24-hour skilled nursing care; and
- They must have resided in a Medicaid-certified facility for 30 consecutive days.

In FY 2007, Texas provided nursing facility care to more than 60,000 Medicaid-eligible and dual-eligible* individuals. For those who occupied Medicaid-funded beds, the average annual cost per resident totaled more than $30,000. This cost does not take into account the portion contributed from applied income, which includes all but $60 per month of a resident's Social Security or SSI payment. Including these costs increases the average annual reimbursement for Medicaid funded nursing facility care to more than $38,000.

3.2.1.2 Primary Home Care

Primary Home Care (PHC) services are less intensive than those provided in a skilled nursing facility, but some of those served would likely reside in a residential facility were PHC services not available. Personal attendants in the PHC program provide non-medical services to assist with the performance of daily tasks, including bathing, dressing, meal preparation, housekeeping, shopping, and making transportation arrangements.

Persons may qualify for the PHC program if they meet the following criteria:

- They are at least 21 years of age;
- Their monthly income does not exceed 100 percent of the SSI income limit

* Dual-eligible clients qualify to receive funding through both Medicaid and Medicare.

(currently $637 per month);
- They have less than $2,000 in assets;
- They meet functional eligibility requirements; and
- They can provide a medical practitioner's statement that their medical condition causes a functional limitation for at least one personal care task.

In FY 2007, almost 60,000 Texans received PHC services at an average annual cost of approximately $7,600 per person.

3.2.1.3 Community Attendant Services

Community Attendant Services (CAS) were put into place to serve those with low to moderate incomes that fall above the eligibility threshold in the PHC program. While PHC is limited to serving persons with incomes less than 100 percent of SSI, CAS services are available to individuals with incomes up to three times the SSI limit, mirroring the financial eligibility requirement for care in a skilled nursing facility.

In FY 2007, more than 40,000 Texans received CAS services at an average annual cost of approximately $7,400 per person.

3.2.1.4 Day Activity and Health Services

The Day Activity and Health Services (DAHS) program provides daytime care at a licensed adult day care facility to individuals residing in the community. Participants receive meals, personal care, physical rehabilitation, transportation, and may take part in planned activities while their primary caregivers are at work. DAHS services are not available in every county.

To be eligible for DAHS services, an individual must meet the PHC income eligibility requirement and have a physician's order requiring care or supervision by a licensed nurse. Participants can be of any age, but the majority of care recipients are elderly.

In FY 2007, more than 17,000 individuals received DAHS services at an average annual cost of just $5,800. Of note, recent rule changes at the Centers for Medicare and Medicaid Services (CMS) may eliminate the federal Medicaid match for DAHS. In response to the proposed change, DADS is working with CMS to apply for a 1915(i) waiver (as authorized by the DRA) to continue to offer DAHS services as part of the state Medicaid plan. It is unlikely that the final outcome with regard to this proposed rule change or the success of DADS' waiver application will be determined before the Texas Legislature reconvenes in 2009.

3.2.2 Waiver Programs

The federal Omnibus Reconciliation Act (OBRA) of 1981 added section 1915(c) to the Social Security Act to provide an option for states to apply for Home and Community-Based Services waivers, which allow states to provide home-based care to individuals who would otherwise be institutionalized. These 1915(c) waivers allow the state to waive certain federal Medicaid requirements and provide services to a set number of individuals so long as the waiver is cost neutral. Cost neutrality means that the average

annual per capita cost of serving waiver recipients cannot exceed the cost of serving those same individuals in an institution.

DADS currently operates seven 1915(c) waiver programs, two of which serve adults who would otherwise require a nursing facility placement. The other five programs provide services to adults and children at risk of placement in an intermediate care facility (ICF) and children with disabilities that make them eligible for placement in a nursing facility. It is important to note that waiver programs are not entitlements. Each biennium, the Legislature appropriates funds to fill a designated number of waiver slots. Once these slots are filled, additional applicants are placed on an "interest list" and must wait for a funded slot to open through attrition. Currently, applicants are served on a first-come, first-served basis without consideration of the individual's level of need.

3.2.2.1 Community-Based Alternatives

Individuals eligible for the Community-Based Alternatives (CBA) waiver program require more intensive services than those provided in PHC or CAS. Because these services are available through a waiver, the state has much more flexibility in tailoring benefits to the recipient's needs. CBA waiver clients may receive personal assistance, nursing, medical supplies, home modifications, respite care, assisted living residential care, adaptive aids, and a variety of other services, depending upon their needs.

To qualify for a CBA waiver slot, an individual must meet the following eligibility criteria:

- They must be 21 years of age or older;
- They must meet the medical necessity and financial eligibility criteria for nursing facility admission; and
- Their Individual Service Plan (ISP) cost cannot total more than twice the reimbursement rate that would have been paid for the person to receive services in a nursing facility.*

In FY 2007, the state provided services through the CBA waiver to approximately 27,000 individuals who would otherwise have been placed in a nursing facility. The average annual cost for services included in participants' ISPs was approximately $15,500—roughly half the cost of nursing facility care. Currently, there are an estimated 30,000 applicants who are waiting to apply for an open CBA slot. Waiting lists for CBA are much shorter than for other waivers that serve persons with developmental disabilities. According to agency testimony provided during the interim, the wait for a CBA slot is approximately two years.

Eligibility criteria for the CBA waiver are identical to those for entitlement nursing facility services. In other words, individuals in the CBA program are eligible for Medicaid-funded nursing facility services and would likely enter a nursing home were it not for this waiver. Serving each of the 27,000 CBA clients in nursing facilities rather

* This requirement helps to ensure overall cost neutrality in the waiver.

than in the community would require an additional $400 million All Funds every year. In other words, the CBA waiver has allowed Texas to save taxpayer dollars, serve aging persons in the setting of their choice, and is one contributing factor to the relatively stable number of individuals served in nursing homes.

3.2.2.2 Consolidated Waiver Program

The Consolidated Waiver Program (CWP) was implemented in 2001 in Bexar County as a pilot to determine whether waiver services could be provided more efficiently under one rather than multiple separate waiver programs with different functional eligibility criteria. Currently, DADS administers seven community-based waiver programs to serve individuals eligible for either nursing home care or ICF services. Persons who qualify for any of these waivers, whether due to aging-related, cognitive, or physical disabilities, is eligible for services in Bexar County through the CWP waiver. Consequently, the population served has a diverse array of disabilities and service needs.

Individuals within the pilot area are eligible to apply if they have been on the county's interest list for any of the 1915(c) waiver programs operated by DADS. Aside from these additional requirements, the eligibility criteria for participation in CWP are identical to those in other 1915(c) waiver programs.

In FY 2007, 182 individuals received long-term care services through CWP at an average cost of approximately $21,000. Were it not for this program, participants would likely be placed in an ICF, state school, or nursing facility, at a substantially higher cost to the state. Even basing a cost comparison on the average cost of care in a nursing facility (as opposed to higher average costs in ICFs and state schools), serving CWP recipients in institutional settings would require an additional $1.6 million All Funds per year.

3.2.2.3 STAR+PLUS

In addition to the waivers operated by DADS, HHSC received 1915(b)* and 1915(c) waivers in 1997 to implement a managed care program for SSI Medicaid clients in Harris County. In January 2007, this model was rolled out to the Travis, Bexar, Nueces, and extended Harris County service areas (Table 2.1). The model is designed to integrate acute and long-term care services for SSI recipients with complex needs, many of whom require long-term care services and supports in the community. Like CWP, STAR+PLUS provides services for both the elderly and younger persons with disabilities.

Enrollment in STAR+PLUS is mandatory for Medicaid recipients in participating service areas who qualify because they receive SSI or because they are participating in the CBA waiver program. Participation is optional for SSI recipients under the age of 21. Individuals with incomes up to 300 percent of the SSI monthly limit who qualify as part of the medical assistance only (MAO) population may sign up for the STAR+PLUS interest list.

* Allows HHSC to limit the provider network to create a Medicaid managed care model.

Table 2.1 STAR+PLUS Service Areas and Participating HMOS, 2007

Service Area	Counties	HMOs	Avg. Monthly Enrollment
Bexar	Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson	Amerigroup, Superior, and Molina	≈ 36,000
Harris	Brazoria, Fort Bend, Galveston, Harris, Montgomery and Waller	Amerigroup, Evercare, and Molina	≈ 77,000
Nueces	Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio and Victoria	Evercare and Superior	≈ 15,000
Travis	Bastrop, Burnet, Caldwell, Hays, Lee, Travis and Williamson	Amerigroup and Evercare	≈ 12,000

Source: Texas Health and Human Services Commission

Once enrolled in STAR+PLUS, individuals must choose a health plan and a participating primary care provider. Those with complex conditions are assigned a service coordinator who is an employee of the health maintenance organization (HMO) offering the health plan. Beneficiaries, family members, providers, and service coordinators work collaboratively to develop a coordinated care plan with the goal of preventing the need for institutional care. Services may include primary and specialty medical care, medical equipment, hospital services, home-delivered meals, attendant care, and adult day health services.

In FY 2007, more than 150,000 STAR+PLUS enrollees were served each month at an average annual cost of approximately $5,000.* Approximately 37 percent (56,000) of these clients were age 65 or older.

3.2.2.4 PACE

The Program for All-Inclusive Care for the Elderly (PACE) was implemented in 1992 in El Paso as an 1115 demonstration waiver project. PACE serves individuals 55 years of age and older who live in a participating service delivery area (currently El Paso or Amarillo, with a site in Lubbock scheduled to become operational in FY 2009) and are certified eligible for nursing care. Under the PACE model, Medicaid, Medicare, and personal resources are pooled to pay a capitated rate† that is lower than the typical cost of providing long-term care services.

PACE services include primary care, behavioral health services, physical and occupational therapy, personal care, and transportation. Care may be provided wherever the individual recipient resides—at home or in a facility— with a focus on maintaining an individual in the home for as long as possible.

* These numbers are based on data from the last six months of FY 2007. Expansion areas were rolled out in January 2007, but enrollment levels did not stabilize (at approximately 150,000 members per month) until March 2007.

† A fixed per capita rate

In FY 2007, Texas was home to approximately 900 PACE participants per month in two locations. The total cost for the program was $25.7 million, for an average annual cost of approximately $28,000.

3.2.3 Money Follows the Person

While PHC, CAS, and 1915(c) waiver programs are designed to prevent the need for institutional care, MFP is a policy designed to move participants from nursing facilities into community-based Medicaid waiver programs. MFP is a nationally recognized strategy and has proven to be a remarkably successful initiative.

From its implementation in September 2001 through February 2008, MFP assisted in transitioning almost 15,000 individuals from nursing facilities into waiver programs. Of these, 57 percent were over the age of 65, and 75 percent never returned, even for a brief period, to a nursing facility. Table 2.2 illustrates the breakdown of participants by placement type after transition into the community.

Table 2.2 MFP Participants by Placement Type

Apartment Setting	*Assisted Living Facility*	*Family Member's Residence*	*Group Home*
22%	28%	45%	5%
≈ 3,200	≈ 4,100	≈ 6,600	≈ 700

Source: Based on data provided by the Texas Department of Aging and Disability Services

In 2001, Rider 37 created the MFP policy to relocate clients from nursing facilities to community care services and to transfer funds from the nursing facility strategy to the community care strategy to cover the cost. In the legislative sessions that followed, slight variations in funding strategies were implemented to pay for MFP. In FY 2005, HB 1867 codified the MFP policy, including it in the budget as a separate strategy. For the 2008-2009 biennium, the Legislature appropriated $81.4 million and $91.3 million, respectively, to fund MFP. In other words, money no longer literally follows the person from the institutional setting into the community.

In FY 2007, 4,640 individuals accessed a waiver slot through the MFP program at an average annual cost of approximately $15,600. These numbers are unduplicated, meaning that MFP slots are not also counted among the CBA slots described previously. If MFP participants were unable to access home- and community-based services and remained in a nursing facility instead, the cost to the state would be an additional $69 million per year. In other words, moving eligible, able, and willing individuals from nursing facilities into the community saves the state money, honors the individual's freedom of choice, and is a permanent option for fully three quarters of individuals who access MFP slots.

3.2.4 General Revenue Services

In addition to Medicaid-funded long-term care and supports, DADS administers the In-Home and Family Support program (IHFS), which is funded purely through GR. The IHFS program provides eligible recipients with up to $1,200 in direct grant benefits per

year to purchase services in their homes and communities.

Purchased services vary according to need but may include attendant care, health services, respite care, or transportation. IHFS is a particularly important program for Texans who are waiting for a 1915(c) waiver slot, but funding is limited. In FY 2008, DADS was appropriated $4 million to provide IHFS services, but more than 14,000 persons remained on the waiting list in January 2008.

Eligibility requirements for IHFS are less restrictive than Medicaid-funded programs. In fact, there are no resource eligibility requirements, but individuals in families with higher incomes are subject to cost-sharing requirements. To be eligible for services, applicants must meet the following criteria:

- They must be at least four years of age;
- They must have a permanent physical disability that limits their ability to function independently; and
- They must meet income eligibility requirement based on the state median income (SMI); copayments on a sliding scale begin at 105 percent of the SMI (currently $2,617 per month).

The sliding scale arrangement means that families with annual incomes greater than $31,400 share the cost of services based on ability to pay, enabling the state to serve more people and allowing middle-income families to access critical services even though they are ineligible for Medicaid. In FY 2007, DADS was able to serve 3,914 individuals through IHFS with available resources at an annual cost of approximately $900 per recipient. DADS estimates that additional funding appropriated in the 2008-2009 biennium will allow IHFS to serve 687 more applicants.

3.2.5 Title XX Services

Federal funds provided as part of the Social Services Block Grant, also referred to as Title XX funds, are a flexible funding source that enable states to tailor social services to the needs of their residents. Federal law specifies that Title XX funds may be used to provide services designed to meet at least one of the following goals:

- To prevent, reduce, or eliminate dependency;
- To achieve or maintain self-sufficiency;
- To prevent neglect, abuse, or exploitation of children and adults;
- To prevent or reduce inappropriate institutional care; or
- To secure admission or referral for institutional care when other forms of care are not appropriate.

Texas received $130.4 million in FY 2007 and $132.7 in FY 2008 to administer its Title XX programs. This funding stream is structured as a block grant without state match or maintenance-of-effort requirements, and Texas is currently drawing down the maximum amount possible. In other words, the state could not receive more federal dollars by investing additional GR, as is the case with entitlement programs like Medicaid.

Title XX services that benefit the aging population with long-term care needs include adult foster care, home-delivered meals, and residential care. Table 2.3 provides greater detail regarding current programs, numbers served, and service costs. DADS estimates that additional Title XX funding appropriated to the agency by the 80th Legislature will allow the agency to serve 2,228 more eligible persons during the FY 2008-2009 biennium.

Eligibility for Title XX services, like most other publicly funded long-term care services and supports, has both a financial and a functional component. Individuals who are 18 years of age or older are financially eligible if they meet the following criteria:

- Their monthly income must fall within 300 percent of the SSI income limit (currently $1,911 per month);
- They may have no more than $5,000 in assets; and
- They must meet the functional assessment score requirements of the program for which they are applying.

Table 2.3 Title XX Services, FY 2007

Service	Average # Served per Month	Average Monthly Cost	# on Interest List
Adult Foster Care	124	$437	122
Consumer Managed Personal Attendant Services	493	$1,033	749
Day Activity and Health Services	1,305	$422	696
Emergency Response (electronic call system)	18,019	$23	7,366
Family Care (non-medical attendant services)	6,422	$450	813
Home-Delivered Meals	16,531	$95	4,645
Residential Care	600	$570	832
Special Services for Persons with Disabilities	132	$669	28

Source: Texas Department of Aging and Disability Services

3.2.6 Area Agencies on Aging

The Older American's Act (OAA) of 1965 established the federal Administration on Aging, which provides funding to state agencies to provide services for the elderly population. In Texas, DADS is the agency responsible for administering OAA funds, and it does so by contracting with a network of 28 Area Agencies on Aging (AAAs), which are most often sponsored by Councils of Governments.*

While AAAs serve each of Texas' 254 counties, funding and available services are not

* There are three exceptions in Texas: the Harris County AAA is sponsored by the City of Houston; the Dallas County AAA is sponsored by the Community Council of Greater Dallas; and the Tarrant County AAA is sponsored by the United Way of Metropolitan Tarrant County.

uniform across the state. DADS allocates OAA funding to AAAs through a federally approved funding formula, but AAAs may also receive state and/or local dollars to provide services based on the specific needs of the communities within their service area. Each AAA works with community leaders and organizations to provide access to needed services and to coordinate the community-based service delivery system with the goal of enabling older individuals to age in place.

AAAs provide services (both directly and through contract) in three categories: access and assistance services; nutrition services, and services to assist independent living. The first category includes benefits counseling and legal assistance, coordination of care and caregiver support, legal awareness, ombudsman services, and information and referral services. Nutrition services include congregate and home-delivered meals, as well as nutrition education. In FY 2007, Texas' AAAs provided almost 95,000 meals to aging Texans. The availability of services to assist independent living vary greatly by region but may include adult day services, respite, personal assistance, residential repair, transportation, health screening, and a number of other services that support aging in place.

While the only strict eligibility criterion for AAA services is that an individual be over the age of 60, limited funding dictates that AAAs target services to individuals with the greatest need. This includes persons with incomes below the federal poverty level (FPL), individuals who lack family or informal support, and those who are at risk of placement in an institution. Because geographical, transportation, and language barriers have a disproportionately negative impact on certain populations, AAAs pay particular attention to three demographic groups: persons with low incomes and minority status; individuals with limited English proficiency, and residents of rural areas.

During FY 2007, AAAs provided services to more than 225,000 individuals with $115.6 million from multiple funding sources, but this represents only about 7 percent of the population over the age of 60. The federal government is the largest single source of AAA funding, with state GR representing only a very small portion (Table 2.4).

Table 2.4 AAA Funding Sources, FY 2007

Federal	$77.3 million	60%
State GR	$5 million	4%
Local (including in-kind and program income)	$45.4 million	36%
Total	$115.6 million*	100%

Source: Texas Department of Aging and Disability Services

4. Long-Term Care Challenges

Services and supports available to Texas' aging population are numerous, but it is not always the case that the right services reach individuals in need in a timely fashion. What's more, failure to ensure that existing programs and services are adequately funded will ultimately undermine the quality of care provided, particularly as the number of

* Not equal to separate source totals as they are rounded to the nearest one hundred thousand dollars.

individuals in need of long-term care services and supports increases. Barriers to an adequate and fully functioning long-term care system include the following:

- Both the number of individuals in need and the intensity of services required are expected to increase in the coming decades;
- Instability in the long-term care workforce prevents the state from building adequate capacity to serve projected need;
- Low reimbursement rates for Medicaid providers have a negative impact on the quality of care and limit the state's ability to grow its provider base to meet future demand;
- Demand for housing and transportation supports for the aging population exceeds supply, making it more difficult for the elderly to age in place, and interagency coordination is limited;
- Existing programs fail to emphasize critical health services, such as routine dental care and mental health care;
- Providers often lack the necessary experience and training to work with aging patients; and
- Challenges facing the state's eligibility system have the potential to interrupt access to services, at least temporarily.

4.1 Demographic Trends

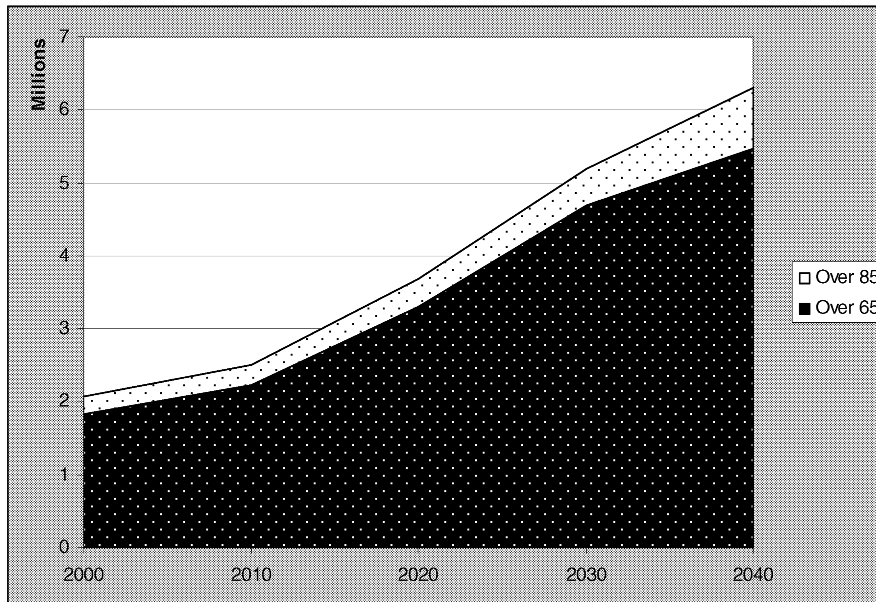
The number of Texans age 65 and older will triple (from 2.1 to 6.3 million) between 2000 and 2040.[4] This dramatic increase in a demographic group for which long-term care needs are relatively common has been characterized by the Texas State Demographer as one of the principal challenges facing Texas and the nation in the 21st century. According to the Center for Demographic and Socioeconomic Research and Education, "services and conditions impacting older persons will become of increasing relevance…in the coming decades,"[5] and it is critical that Texas work to prepare for the expected increase in demand for services.

Within the aging population, at least two significant changes are expected to occur. Over the next three decades, the 65+ population will become older and more diverse, with 85+ and non-Anglo members constituting an ever-increasing percentage of the elderly. In 2000, there were an estimated 238,000 Texans age 85 or older; by 2040, this number is projected to reach 831,000 (see Figure 2.4). Additionally, Anglos will constitute only 44 percent of older Texans in 2040, compared to approximately 70 percent today.[6]

These demographic shifts, combined with changing cultural norms regarding the setting of long-term care service provision, will require both increased capacity and realignment within the state's long-term care system. On the one hand, the number and percentage of aging Texans who opt for home-based services will continue to grow, and this service sector will be required to keep pace with demand. On the other hand, many of Texas' elderly over the age of 85 will likely continue to require care in more formal settings, necessitating some growth in nursing facility capacity. What's more, the oldest age group will likely continue to increase proportionally among those served in nursing

facilities. Because members of this demographic group generally have a greater number of functional limitations, it is reasonable to predict that the job of nursing facilities will become increasingly demanding.

Figure 2.4 Projected Growth of 65+ Population



Source: Texas State Data Center as reported by the Texas Department on Aging[7]

4.2 The Long-Term Care Workforce

The age group from which the long-term care workforce typically draws, however, will not keep pace with the growth among the elderly population. Consequently, workforce recruitment and retention will become increasingly critical, particularly for direct service workers (DSWs) who provide the vast majority of paid long-term care services and supports. While much attention has been given to the impact of physician and nursing shortages, there has been less focus on the shortage of paraprofessional health care workers, the backbone of the long-term care system.

DSWs fall into three basic categories:

- Certified nursing assistants (CNAs) are typically employed in formal long-term care settings, such as assisted living and nursing facilities. They provide direct, hands-on assistance with ADLs (e.g., toileting, bathing, dressing, and eating) and perform certain clinical tasks.
- Home health aides work perform a similar function but work in community-based settings. In addition to the services provided by CNAs, home health aides are also required to assist with instrumental ADLs (e.g., shopping, housekeeping, and cooking) to support a client's ability to remain in the community.
- Personal care attendants also work in community-based settings and provide employment and transportation support in addition to all the functions of a home health aide.[8]

As the aging population and the demand for home and community-based services grow, maintaining an adequate supply of DSWs will become increasingly important; without an adequate number of qualified personal care attendants and home health aides, many aging Texans will not have access to the necessary supports to age in their community. Maintaining an adequate supply of DSWs, however, has become more challenging. In the face of rising demand, coupled with a shrinking workforce and turnover rates of more than 100 percent,[9] a coordinated effort to recruit and retain DSWs is essential.

The Texas Direct Service Workforce Initiative conducted stakeholder interviews in 2006 to identify the underlying causes of high turnover rates among DSWs. including:

- **Low wages**. The median hourly wage for personal care attendants and home health aides ($6.41 and $7.17, respectively) falls below the living wage for a single adult in Texas ($7.45);
- **Inadequate benefits.** Most DSWs do not have access to affordable employer-sponsored health coverage, paid sick leave, or vacation time;
- **Insufficient job preparation.** A lack of training leaves many DSWs ill prepared and without a clear sense of the job's demands; and
- **Lack of opportunity.** Many DSWs work for years in the same job without receiving a raise.[10]

Addressing these issues will become more important in coming years, particularly as the state continues to prioritize long-term care services provided in the community.
The capacity of the state's community-based long-term care system is dependent almost entirely upon its direct service workforce. If Texas cannot ensure an adequate supply of DSWs, there will be no way to continue caring for the elderly in their homes and communities. The state must explore creative ways to incentivize growth in this sector, and a foundational piece of the solution is linked directly to improving reimbursement rates for the services provided by personal care attendants and home health aides.

4.3 Reimbursement Rates

Reimbursement rates for both nursing facility and community-based providers in Texas lag behind those in other states. Texas currently ranks 49th among all states in reimbursement rates for nursing facility care, at almost $40 lower per resident day than the national average,[11] and last among states that reimburse for personal care attendant services (Appendix D). Better alignment of reimbursement rates with the cost of providing long-term care services would improve the ability of nursing facilities and home health agencies to recruit and retain qualified staff, which in turn is linked to adequate system capacity and the quality of care.

4.3.1 Nursing Facility Rates

HHSC employs a standard, cost-based methodology to determine rates for nursing homes with which it contracts to provide Medicaid services. Every year, each facility submits a report detailing, among other information, the total number of resident days, Medicaid and non-Medicaid revenue, and costs incurred in each of five components: direct care staff (e.g., wages and benefits for nurses and aides) other resident care costs (e.g., wages

and benefits for support staff and payments for contracted services); dietary care costs; facility and operations costs; and administration costs.

Once the data have been collected from every facility in the state, HHSC calculates the average cost per resident day for each of the two patient care cost components, a median for the dietary and administrative components, and a facility use fee based upon the array of facility appraised values. The sum of these calculated amounts, after being adjusted for inflation and grossed up by 7 percent,* becomes the recommended Medicaid reimbursement rate. Two of the rate components (*direct care staff* and *other resident care costs*) are weighted according to the acuity level of the patient; all other components are fixed. HHSC does not consider national averages or outside recommendations in determining these rates. Rather, the agency's recommended rate is based solely on standard, verifiable reports of the costs that Texas' nursing homes incur in caring for their residents.

As recently as 1992, the Legislature appropriated adequate funds to reimburse nursing facilities for the average cost of caring for Medicaid patients (as determined by the methodology). Since 1992, however, the percentage of nursing facility costs covered by the approved reimbursement rate has declined dramatically. For the 2008-09 biennium, the Legislature approved an 8 percent rate increase for nursing home reimbursement rates, but much more would have been necessary to align average Medicaid reimbursement with the average cost of care.† HHSC recommended an average daily rate of $119.99 for nursing facility care in FY 2008. Based on allowable costs, this rate would cover the cost of serving Medicaid clients in the average nursing facility. The Legislature appropriated enough funds to provide an average daily rate of $106.91, which covers the cost of serving Medicaid patients for only about one in four facilities.[12]

To put this $13 difference between cost and the appropriated reimbursement rate in perspective, it is useful to consider what this might mean for the average nursing facility. This facility would have 108 beds, approximately 81 of which would be occupied on any given day. Of these 81 beds, 58 would be occupied by a Medicaid client. If the cost of care in this facility were also average, the nursing home would essentially lose $275,000 per year in serving its Medicaid clients under the current scenario.‡ The facility would then be required to employ strategies to make up for this loss. If, however, the reimbursement rate were fully funded, the facility would break even with regard to the cost of serving Medicaid clients and have $275,000 additional dollars to spend on facility improvements, additional staff, improved training, and better employee compensation. This would have a positive impact on the quality of care for *all* persons served in the facility, including private payors, Medicare and Medicaid recipients, and those covered by long-term care insurance plans.

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* This fixed percentage has two purposes: to account for any possible errors (e.g., higher-than-anticipated inflation rates); and to ensure that recommended rates cover the costs of a Medicaid facility with costs slightly higher than the average.

† The Legislature approved $99 million in GR, but it would have required an additional $240 million to cover the gap between reimbursement and cost of care.

‡ According to the Texas Health Care Association, the average nursing home has 108 beds, is at 75 percent occupancy, and 71 percent of occupied beds are Medicaid-funded.

As facilities face reimbursement rates that cover an ever smaller proportion of the cost of care, they tend to respond as the market would predict, with a strategy or combination of strategies to reduce expenditures and/or increase revenue. Reducing employee wages and benefits and forgoing needed capital improvements, two logical results of inadequate reimbursement rates, run the risk of compromising the quality of care. In some cases, facilities may close in areas where Medicaid beds make up a large proportion of the census, disproportionately affecting rural and low-income populations.*

Since Medicaid reimbursement rates are fixed, a facility's options to increase revenue are limited. Non-profit nursing homes, which often have diverse funding streams, may have greater flexibility, while for-profit facilities have fewer options. Most must shift a portion of Medicaid losses to private payors and simultaneously shift the payor mix to favor Medicare and private-pay beds. In reality, this means that the $275,000 annual loss that the average facility experiences in serving Medicaid clients is ultimately shifted to private payors and that individuals covered by Medicaid will have a more difficult time accessing care than those covered by Medicare or paying out-of-pocket. Perhaps most problematic from a policy perspective is the fact that cost-shifting strategies ultimately cause a private payor to exhaust personal funds and become Medicaid-dependent earlier than they would have otherwise.

In short, failing to fund the full cost of care in Texas' nursing facilities may save state dollars in the short-run, but it is counterproductive in the middle and long run. Underfunding Medicaid rates preserves GR at the expense of the private consumer and taxpayer and increases future state outlays by making private-pay less affordable and dependency on Medicaid more likely. Most importantly, it prevents the investment of needed dollars to build capacity, modernize facilities, strengthen the workforce, and improve the quality of care for all Texans who reside in nursing homes.

4.3.2 Community Care Rates

Reimbursement for services provided in the community is not based on a daily rate intended to capture all cost components as is the case in a nursing facility. Rather, because the lion's share of community care service costs are related to workforce compensation, the majority of reimbursement rates are hourly and vary by category of health care provider. What's more, rates differ across programs, as the acuity level of clients tends to vary across programs.

As an example, in the CBA and CWP waiver programs, one registered nurse hour is reimbursed at $43.39, one licensed vocational nurse hour costs the state $29.69 per hour, the rate for physical therapy is $66.88 per hour, and personal assistance services are reimbursed at a base rate of $10.86 per hour. In the PHC and CAS programs, in which the needs of clients are generally less intensive, the rate for personal assistance services is lower, at $9.61 per hour.[13] This rate is paid to the home health agency and is intended to cover costs associated with the provision of that hour of care, including administrative costs. In other words, the personal care attendant, nurse, or physical therapist receives

* See Appendix E for data relating to recent nursing home closures.

less than this amount as his or her hourly wage.

While reimbursement rates for community-based providers are structured somewhat differently than those for nursing facilities, the principal is the same. Providers report allowable costs related to service support (e.g., field supervisor salary, benefits, and fuel costs and agency overhead, excluding interest and depreciation) and attendant compensation. Using inflation indices, HHSC projects providers' costs over the upcoming biennium, and this number is divided by the total units of care provided (i.e., hours spent with the client). HHSC then determines the median* cost of care for each type of service, grosses it up by 4.4 percent,† and this becomes the recommended hourly rate for one unit of care by a particular provider category within a particular program.

As is the case with nursing facility reimbursement, the majority of community-based services are also funded at rates well below the recommended methodology. In 2007, the Legislature appropriated enough funds to cover a little over one third of the recommended rate increase, but this increase was not distributed evenly across all types of providers. For example, in the CBA and CWP waiver programs, occupational therapy, speech pathology, and pre-enrollment assessment services are funded at 100 percent or more of the recommended rate. In contrast, only 92 percent of the rate for personal attendant services and 86 percent of the rate for skilled nursing services is funded (Table 2.5). It is important to recognize that the vast majority of service hours provided by home health agencies fall in these two underfunded categories.

Table 2.5 Percent of Cost/Recommended Rate Funded for Nursing Facility and CBA/CWP Waiver Services

	Rate Period			
	SY 2004-05	*Sept.-Dec. 2005*	*Jan.-Aug. 2007*	*FY 2008*
Nursing Facility	90%	82%	89%	89%
Personal Attendant Services	94%	96%	96%	92%
Registered Nurse	96%	87%	87%	86%
Licensed Vocational Nurse	89%	83%	83%	100%
Physical Therapy	91%	100%	100%	96%
Occupational Therapy	93%	100%	100%	101%
Speech Pathology	86%	100%	100%	102%
In-Home Respite	73%	93%	93%	95%
Pre-Enrollment Assessment	93%	89%	89%	100%

Source: Texas Health and Human Services Commission

Home health agencies typically serve Medicare and Medicaid clients through separate programs, so cost shifting is not as significant a problem as is the case with nursing

* The median is the middle of the cost distribution. Half of providers spend more than the median cost to provide one unit of care, while half spend less.

† This fixed percentage has two purposes: to account for any possible errors (e.g., higher-than-anticipated inflation rates); and to ensure that recommended rates cover the costs of slightly more than half of agencies serving Medicaid clients.

facilities. When agencies are not paid adequate rates to recruit and retain qualified providers, however, the needs of Medicaid clients simply go unmet, even if they are eligible for and enrolled in the appropriate programs. For example, an individual may qualify for ten hours per week of personal attendant services to help with grocery shopping, meal preparation, and housekeeping so that he or she may remain at home. It may also be the case, however, that the home agency in that area can only find an available personal care attendant to cover five hours. In a case like this, the individual would only receive five hours of support services rather than the ten for which he or she was eligible. This scenario is particularly common in rural areas, where rising fuel prices have had a substantial impact on the ability of agencies to find workers willing and able to drive long distances to serve their clients. The effect on a client without a supportive network of family and friends is most severe, and many of these individuals could end up in a nursing facility if they do not receive necessary services at home. In other words, funding has a direct impact on the capacity of community-based care.

4.4 Barriers to Aging in Place

When individuals choose to remain in their homes and communities as they age. necessary long-term care services and supports may extend beyond traditional health care and personal assistance services. For many, limited access to affordable housing and public transportation present barriers to aging in place.

4.4.1 Housing Costs

Many aging Texans live on fixed incomes, yet the cost of housing, particularly for those who rent, rises annually. This can present a significant challenge, most often for seniors with low incomes. In Texas, 300,000 individuals ages 65 and up live below the poverty line, and more than a million live with incomes below 200 percent of the FPL.[14] Covering rent, rising energy costs, property taxes, and necessary home repairs is often difficult for these individuals.

DADS administers some funding through its AAAs to provide home repairs for seniors who are aging in place, serving 1,855 persons in FY 2007. The provision of affordable housing and support services, however, is outside the purview of DADS. The Texas Department of Housing and Community Affairs (TDHCA) is the state's lead agency on affordable housing and community services, but TDHCA is charged with serving low-income Texans in all age groups. TDHCA, along with public housing authorities, administers programs that provide rental assistance, rent-restricted housing, home repair assistance, and energy assistance. Not all those who are eligible, however, are served, and not all of those served are seniors. In other words, the specific housing needs of low-income seniors who wish to age in place are not addressed by a single agency, but by two agencies with overlapping missions.

4.4.2 Limited Public Transportation

Seniors who remain in their homes require transportation to purchase food and medicine, access health care services, and to maintain social contacts. While the majority of individuals over the age 65 continue to drive for some time, one in five seniors nationwide is no longer able to do so.[15] These individuals must rely on friends, relatives,

and public transportation, yet approximately three quarters live in rural and suburban areas with limited public transportation options.[16]

As is the case with housing, however, transportation is not a central components of the long-term care services and supports administered by DADS. AAAs provided some transportation assistance to approximately 11,000 aging Texans in FY 2007, and some personal care attendants assist with transportation as well. Public transportation options include a patchwork of urban and rural transit systems, individual city initiatives, and private, non-profit programs.

4.5 Gaps in Care

As many stakeholders have observed, high-quality health care extends beyond the provision of traditional medical services and should incorporate preventive care, chronic disease management, and mental health care. Many aging Texans, however, face barriers to accessing these critical services.

4.5.1 Preventive Dental Care

Currently, Medicaid benefits for persons in nursing facilities include oral hygiene services and emergency dental care. Routine and preventive care, however, such as x-rays, regular cleaning, and restorative procedures (e.g., dentures) are not covered, despite the fact that quality of life, nutrition, and physical health are directly related to oral hygiene.

Individuals in nursing homes may use applied income* to pay for preventive dental services. This extra step unnecessarily complicates the process, as Medicaid must contribute either way. For example, if a nursing facility resident pays $600 of his or her applied income for dental care, the Medicaid program compensates the facility for the "missing" applied income contribution.

In an attempt to simplify this process and make Medicaid more readily accessible to nursing facility residents, the 77th Texas Legislature passed SB 34. This piece of legislation expands Medicaid coverage to include annual dental exams, diagnostic x-rays, and dental cleaning, but the expansion has never been funded.

4.5.2 Mental Health Services

According to the United States Surgeon General, up to 20 percent of elderly adults in community settings present symptoms of depression, which are commonly misdiagnosed.[17] Caregivers who have regular contact with seniors, including DSWs, family members, and community service volunteers are often the first to recognize problems and can be a valuable source of information. Despite this fact, many community-based programs, including adult day-care services, fail to incorporate basic mental health screenings and care into the array of available services.

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* Medicaid eligibles who also receive Social Security or SSI must apply all but $60 per month of this income towards the cost of nursing home care to offset the cost to Medicaid.

4.6 Geriatric Training

As with any age group, older adults often have unique medical needs that can best be met when their caregivers have adequate expertise and training. Current medical education, however, rarely includes geriatric instruction. There would be widespread concern if general physicians who lacked any pediatric training regularly prescribed medication or performed medical interventions for children. It is widely understood that the side-effects of drugs and other medical procedures may be very different for a child than for the typical adult.

Unfortunately, this scenario occurs regularly among physicians who treat elderly Texans, and the quality of the health care provided to aging individuals suffers as a result. Some physicians who lack geriatric training overprescribe medications or recommend ineffective procedures—one in four Medicare beneficiaries has experienced an adverse drug reaction.[18] Untrained physicians may also be more likely to misdiagnose a patient. In each of these examples, the quality of care is diminished, and limited health care resources are used ineffectively.

4.7 Texas' Eligibility System

Access to all Medicaid services is dependent upon a fully functional eligibility system, yet Texas' local eligibility offices and Integrated Eligibility and Enrollment System have struggled in recent years to process applications in a timely manner. Systemic problems are primarily the result of staffing cuts and inadequate numbers of staff trained to use the Texas Integrated Eligibility Redesign System (TIERS). At present, HHSC is planning to convert all individuals enrolled in Medicaid for the Elderly and People with Disabilities (MEPD) beginning in December 2008 and continuing through September 2009 into the TIERS system, and it is of critical importance that this transition be completed without interrupting services for this vulnerable population and without placing undue burdens on the providers who serve them.

According to HHSC's plan, the cases of almost 1 million Medicaid-eligible elderly and persons with disabilities will be converted into TIERS in four distinct roll-out phases. To ensure that this process goes smoothly, HHSC has elected to keep the functional eligibility determination component out of TIERS and within the IT system at DADS. This is intended to avoid some of the past problems with MEPD conversions into TIERS, including large provider recoupments when levels of care and need were not assigned appropriately in the TIERS program. Recent programmatic decisions, along with increased efforts to train staff and make technological improvements, are encouraging. Nevertheless, it is of utmost importance that the transition be monitored carefully over the coming year, and that providers, caretakers, and clients be informed regarding where to receive help should problems occur.

5. Quality Incentive Initiatives

Many of the challenges highlighted in this report are due in large part to inadequate public investment in long-term care services, yet calls for increased funding have understandably been accompanied by demands for greater accountability and an assurance that additional public dollars will be spent to improve the quality of care.

Recently, some stakeholders have focused on initiatives to improve quality, transparency, and accountability through value-based purchasing, recommending that Texas follow in the footsteps of states like Oklahoma and Georgia that have implemented pay-for-performance strategies. These programs compensate providers based on their ability to meet quality-of-care measures, including staffing levels, turnover rates, employee and resident satisfaction, and compliance with regulatory standards. Data for participating facilities are compiled and published on a consumer website to help the public make informed decisions regarding their long-term care needs, and facilities receive bonuses for good performance.

Although pay-for-performance initiatives have much potential, it is important to recognize that strategies to incentivize quality-of-care improvements will only be effective if the existing system is adequately funded. In other words, while it is certainly reasonable to demand increased transparency and quality from providers, there is no cost-free strategy to ensure adequate capacity and quality in the future.

In fact, pay-for-performance strategies are not a new idea in Texas. In 1999, recognizing the link between quality of care and staffing levels, the Legislature established an enhancement program to incentivize providers to improve staffing levels and reduce turnover through a direct investment in staff. Participating providers receive an enhanced rate, 85 percent of which must be spent directly on staff compensation and benefit costs (90 percent in the case of community care providers). Failure to meet this spending accountability requirement results in the recoupment of all, or a portion, of the staff enhancement add-on, and recouped dollars are redistributed to providers that exceed staffing targets. While participation in the program is optional, the majority of Texas' providers have elected to enroll in these programs.

Despite widespread participation, insufficient funding for the enhancement program has limited its efficacy. Currently, the level at which some providers are allowed to participate is restricted, and many providers who would like to do even more to improve staffing levels and workforce compensation are not reimbursed through the existing enhancement program. What's more, monetary incentives for nursing facilities, which are intended to reflect the costs of providing additional minutes of direct care staff time per resident day, are actually significantly lower than the average costs of providing that additional care. This, in combination with inadequate base rates, has caused the staffing enhancement program to act in many cases as a "catch-up" mechanism for underfunded providers struggling to retain qualified workers, rather than as a vehicle for increased staffing levels, which was its original intent.

In an environment where the cost of care is only partially reimbursed, and enhancement programs fail to reflect the true cost of the outcomes they expect to incentivize, quality improvements are difficult to achieve. The logic of adequate base rate funding as a necessary precondition for incremental quality improvement programs is actually recognized in current statute. Specifically, Human Resources Code §32.028 (g) requires that any quality incentive program, including a pay-for-performance initiative, be

conditional on full funding of the rate methodology:

> *(g) Subject to Subsection (i), the Health and Human Services Commission shall ensure that the rules governing the determination of rates paid for nursing home services improve the quality of care by:*
>
> > *(1) providing a program offering incentives for increasing direct care staff and direct care wages and benefits, but only to the extent that appropriated funds are available after money is allocated to base rate reimbursements as determined by the Health and Human Services Commission's nursing facility rate setting methodologies; and*
> >
> > *(2) if appropriated funds are available after money is allocated for payment of incentive-based rates under Subdivision (1), providing incentives that incorporate the use of a quality of care index, a customer satisfaction index, and a resolved complaints index developed by the commission.*

6. Conclusion and Recommendations

In light of the challenges facing Texas' long-term care system, both today and in decades to come, the House Committee on Human Services makes the following recommendations:

1. **Support efforts to keep aging individuals in the community for as long as possible, including:**

    a. Reducing interest lists for community-based waiver programs;

    b. Exploring strategies, including the provision of respite services, to support informal caregivers;

    c. Fully fund the recommended rates for personal assistance and registered nurse services to build community capacity by supporting a better compensated and more qualified direct service workforce;

    d. Streamlining the licensing, casework, and reporting requirements for community care providers;

    e. Supporting the Department of Assistive and Rehabilitative Services; (DARS) request for $500,000 GR ($1.9 million All Funds) for grants to fund three additional CILs;

    f. Supporting community-based and volunteer-driven initiatives to provide seniors with needed services in their own homes; and

    g. Supporting efforts to prevent accidents in the home that may hasten the need for facility-based care (e.g., fall prevention initiatives).

2. **Fully fund the base rate for nursing facilities to ensure that:**

    a. Nursing facilities have the opportunity to recruit, train, and retain high-quality staff;

    b. The impact of rising energy and food costs does not have a negative impact on the quality of care;

    c. Physical plants are updated and comply with current safety standards;

    d. Rural and other facilities that rely disproportionately on Medicaid funding can continue to serve the aging population;

    e. The cost of Medicaid care is not shifted to the private payor; and

f. Individuals in need are not forced to use higher cost hospital settings.

3. **The idea of using a pay-for-performance model to improve transparency and accountability and incentivize higher quality in nursing facilities is promising. Pursuant to current statute, however, the implementation of any pay-for-performance initiative should be conditional upon full funding of the base rate as recommended by HHSC methodology.**

4. **Transportation and housing supports are provided by numerous agencies outside the jurisdiction of the House Committee on Human Services, including TXDOT and TDHCA. What's more, any effort to develop and improve the direct service workforce will likely involve both the Texas Workforce Commission (TWC) and the Texas Education Agency (TEA). For this reason, the Legislature should establish a Joint Committee on Aging and Long-Term Care Issues to be made up of members from the House and Senate, as well as public representatives. This committee would be charged with:**

   a. Reviewing recommendations by state agencies that serve the aging population and provide direct service workforce development;

   b. Reviewing recommendations from providers and other public stakeholders regarding issues related to aging and long-term care;

   c. Making recommendations for legislative action; and

   d. Issuing a report that identifies priorities in preparing for an aging population, including those related to transportation, housing, and workforce development.

5. **Fund preventive dental care for Medicaid recipients in nursing facilities.**

6. **Modify Texas Administrative Code (40 TAC §98.2) to include mental health as a component of health assessments at adult day care facilities.**

7. **Explore strategies to expand geriatric training to all health professionals who work with older adults, in both facility-based and community-based long-term care settings.**

   a. Any proposed training program should recognize that required knowledge will vary by category of provider; and

   b. Any proposed training program should address critical health-related issues among the elderly, including dementia, depression, delirium, medication, incontinence, elder abuse, palliative care, and fall prevention.

8. **Ensure that Texas' eligibility system is fully functional, and monitor the conversion of MEPD cases into TIERS to make certain that:**

    a. Individuals requiring long-term care services and supports receive services for which they are eligible in a timely manner; and

    b. Long-term care providers do not experience uncharacteristic delays in or unwarranted recoupment of reimbursement for Medicaid services rendered.

9. **Support efforts statewide to assist seniors and their families with benefits counseling, casework, and information, referral, and assistance.**

7. Testimony and Public Comment

The House Committee on Human Services heard testimony on its second interim charge at two separate hearings (March 13, 2008, at the University of Houston Clear Lake and May 1, 2008, at the Texas State Capitol in Austin). Testimony was provided by HHSC, DADS, the Texas Department of Insurance (TDI), the Oklahoma Health Care Authority stakeholder groups, and the public at large. This section summarizes public and written testimony received by the committee relating to improving the quality of long-term care services for aging Texans.

7.1. Health and Human Services Commission

Tom Suehs, Deputy Executive Commissioner for Financial Services, and Pam McDonald, Director of Rate Analysis for Long-Term Care, provided testimony on March 13 regarding the long-term care rate methodology, current and historical rates, and staffing enhancement programs. HHSC's rate recommendations are informed by cost reports that have been audited by the Office of the Inspector General, as well as cost inflation indices.

In nursing facilities, rate components include direct care staff and other resident care, which are adjusted according to the acuity of the patient. Costs related to dietary care, general and administrative functions, and capital asset use are fixed. Nursing facilities may also receive add-on payments if they have liability insurance, participate in the staffing enhancement program, and/or serve residents who are dependent upon ventilators or children with tracheostomies.

The current weighted average nursing facility rate (as of January 2008) is $108.88 per day of service. The rate recommended by HHSC for FY 2008 through application of its rate methodology was just under $119.99 per day of service, but appropriated funding supports a rate of only $106.59. The rate funded through appropriations has been consistently below the recommended rate in recent years.

Community-based providers receive an hourly rate based on the provider utilized (e.g., personal assistant, registered nurse, or physical therapist). For some provider services, the rate is fully funded (e.g., speech pathology). For others, it is not (e.g. personal attendant services).

Staffing enhancement programs for both nursing facility and community-based care operate subject to funding availability. Participation is optional, but the majority of all providers participate to some degree. Participating providers agree to spend a set percentage of direct care revenues on staff compensation, including salary, payroll taxes, and benefits. If they fail to meet this requirement, the state may recoup all or a portion of their incentive payment.

On May 1, Audrey Deckinga, Senior Policy Advisor, provided testimony regarding HHSC's role in the Long-Term Care Partnership. Currently, Medicaid pays for almost half of all long-term care and more than two thirds of nursing facility care. With the aging population expected to triple, Medicaid long-term care costs could nearly

quadruple from $3.5 billion in 2005 to $12.5 billion by 2040.

Authorized by the federal DRA, and SB 22 (80R), the goal of Texas' Long-Term Care Partnership is to encourage individual planning for long-term care needs instead of relying on Medicaid-funded services. The Texas program will allow dollar-for dollar asset protection at Medicaid eligibility. Qualified plans must include inflation protection, have adequate benefit levels, be transferable to another state with a partnership program, and be tax qualified. Thirty-five other states are developing or have developed partnership programs.

7.2 Department of Aging and Disability Services

On March 13, Commissioner Adelaide Horn provided testimony regarding DADS-administered services available to aging Texans. These services include Medicaid-funded entitlements in the community and in nursing facilities, Medicaid waiver programs, MFP, GR-funded services, Title XX services, and services available through AAAs.

Commissioner Horn also described current efforts in Texas to prepare for an aging population: the creation of Aging and Disability Resource Centers (ADRCs); organization of community roundtables; the Long-Term Care Partnership Program; the White House Conference on Aging, the Aging Texas Well Initiative; the Texercise program; and the Texas Falls Prevention Coalition.

In 2005, DADS received a three-year ADRC grant from CMS and the Administration on Aging. Pilot projects are located in Bexar County, Central Texas, and Tarrant County. The primary objectives of ADRCs are to streamline access and assistance to older adults and persons with disabilities, work collaboratively at the community level, and serve as resources for individuals eligible for public programs, as well as those with private resources.

In 2007, DADS assisted with planning and convening community roundtables in eight locations around the state to determine how best to integrate access to DADS services. Ideas resulting from the roundtables that DADS is working to implement include shared referral forms, inter-agency training plans, united marketing activities, and employing the use of system navigators to help individuals understand the DADS system of services.

Long-term care partnerships are public-private partnerships to make affordable, high-quality LTC insurance available to individuals with moderate incomes. SB 22 (80R) requires HHSC, DADS, and TDI to work together to establish a long-term care partnership in Texas.

The White House Conference on Aging is held every ten years to inform the President and Congress on aging issues. The Texas delegation is appointed by the Governor, members of Congress, and a policy committee. Delegates from around the country meet to discuss and vote on the top 50 priorities from a list of resolutions. After the conference in 2005, DADS partnered with the Texas Silver-Haired Legislature and AAAs to host 14

local solutions forums around the states to solicit ideas regarding how to implement conference resolutions.

The Aging Texas Well initiative was begun in 1997, pursuant to Executive Order RP42. Aging Texas Well aims to improve individual preparedness and social infrastructure for aging Texans by engaging communities and encouraging them to prepare for an aging population.

Texercise is a statewide intergenerational fitness program that educates and involves individuals and communities in adopting healthy lifestyles through the promotion of physical activity and proper nutrition and the provision of resources (e.g., handbooks, pedometers, and exercise equipment) to motivate activity.

The Texas Falls Prevention Coalition began in June 2007 as a collaborative partnership between the Texas Association of AAAs and the Texas A&M Health Science Center School of Rural Health. Falls account for 70 percent of all emergency room admissions among older adults and 40 percent of nursing home placements. The coalition aims to improve fall prevention and change attitudes and behaviors that predispose older persons to falls.

Commissioner Horn concluded her presentation with an update on the implementation of Rider 38, which directed HHSC and DADS to study the possible implementation of the Alzheimer's Nursing Facility Medicaid Rate Add-On. The study was not complete by March 13, but a final report was issued in August 2008. While specific recommendations were not included in the final report, DADS and HHSC noted that an Alzheimer's add-on would have a significant fiscal impact, as an estimated 5,700 nursing facility residents suffer from Alzheimer's. DADS also noted that the implementation of Resource Utilization Groups (RUGs) in September 2008 will result in a higher reimbursement rate for the Alzheimer's population than under the current system.

7.3 Texas Department of Insurance

Ana M. Smith-Daley, Deputy Commissioner, provided testimony on May 1 regarding long-term care insurance and TDI's role in Texas' Long-Term Care Partnership. Ms. Smith-Daley described the long-term care insurance market, including group and individual coverage options, and noted that approximately 389,000 Texans currently have long-term care insurance.

Benefits and requirements vary, but most policies do not pay for all long-term care expenses, may exclude pre-existing conditions, have an elimination period before coverage can begin, and do not provide cash surrender values.* Policies may be comprehensive, or they may cover only facility-based or community-based services. Currently, 35 carriers offer long-term care insurance in Texas.

TDI is currently working to adopt the rules that will govern policies eligible for inclusion

* This is the amount available in cash upon cancellation of a policy, which may occur in cases where an individual is no longer able to afford the premium.

in the Long-Term Care Partnership. It is anticipated that these rules will be published and policies will be available beginning September 2008.

7.4 Care for Elders
Jane Bavineau, Executive Director, provided testimony on March 13 regarding the role of personal attendants and efforts to coordinate access to services. Morgan Carnes, Project Manager of Quality and Workforce Initiatives contributed written testimony.

Personal attendants are critical components of the home care industry and perform physically, mentally, and emotionally demanding jobs. These workers, however, are often minimally trained and supervised and make less money than fast-food employees. Action should be taken to improve the quality of the workforce.

Texas 211/United Way helpline could play an important role in providing enhanced information and referral services. Resources are available to health clinics, service providers, faith-based organizations, older adults, senior centers, and concerned family and friends. Help lines in Harris County connect the caller with Resource Specialists and Field Specialists who specialize in services for elders.

7.5 Meals on Wheels Association of Texas
Meals on Wheels representatives Dan Pruett, Michael Goldstein, Bridget Samuel, and Betty Bradley, provided testimony on March 13 and May 1 regarding the Meals on Wheels program, a program assisting the homebound elderly and persons with disabilities who wish to age in place. These representatives underscored the role that home-delivered meals programs play in avoiding or delaying the need for placement in assisted living and nursing facilities, thanked the Legislature for establishing the Home-Delivered Meal Grant Program during the 80th Regular Session, and encouraged continued support for this program.

On March 13, Mr. Pruett highlighted challenges faced by Texas' elderly individuals aging in place, including meals, transportation, home repair, housing and utility costs, and depression. According to both Mr. Pruett and Mr. Goldstein, funding for programs like Meals on Wheels supports the elderly in their homes, leverages volunteers and community resources, and saves the state money.

On May 1, Ms. Bradley spoke to the impact of rising food and fuel costs on the state's elderly population. Additionally, she highlighted the critical services offered by organizations that provide home-delivered meals, including a safety net and regular social interaction for individuals who live alone.

7.6 American Association of Retired Persons, Texas
Amanda Fredriksen, Director of Advocacy, provided testimony on March 13 regarding the importance of community-based care and the direct care workforce. Ms. Fredriksen advocated for easily accessible community-based supports to help individuals stay at home and prevent or delay the need for nursing facility care. Ms. Fredricksen also underscored that high-quality nursing home care has an important role to play in the long-

term care continuum, but these resources should be reserved only for those who really can't be served in their own homes. She recommended increasing reimbursement rates to improve the quality of the direct service workforce.

7.7 Texas Health Care Association

Tim Graves, President/CEO, provided testimony at both hearings on the committee's long-term care charges. On March 13, Mr. Graves gave an overview of Texas' nursing facilities and funding issues. On May 1, he focused on the impact of inadequate reimbursement rates, the potential impact of pay-for-performance strategies on the quality of care, and the role of long-term care insurance.

Currently, more than 1,100 nursing facilities operate in Texas. The average resident is female, more than 85 years old, and needs help with at least four activities of daily living. The vast majority of Texas facilities (95 percent) accept Medicaid. While 71 percent of care is Medicaid-funded, Medicaid contributes less than 55 percent of nursing facility revenue. Facilities must maintain a favorable payor mix in order to stay in business, which means maximizing the number of private-pay and Medicare beds.

The need to favor payors other than Medicaid is the result of more than a decade of underfunded Medicaid reimbursement rates for long-term care facilities. Today, Texas ranks 49th in the United States in funding for Medicaid care, with rates more than $47 per patient day below the national average. As a result, turnover among direct care staff in nursing facilities is 134 percent, the average nursing home in Texas is over 30 years old and needs significant upgrades, 45 facilities have closed since January 2006, and 11 Texas nursing homes are in Chapter 11 status. Rural nursing homes are hardest hit by low Medicaid rates due to their lack of offsetting Medicare revenue. What's more, some facilities will be negatively affected by the upcoming transition to RUGS.

Mr. Graves expressed some concerns regarding the relatively new focus on pay-for-performance initiatives. While greater transparency and accountability are important, quality incentives will not have the desired effect in Texas without adequate investment in the current system.

Finally, Mr. Graves cautioned against overreliance on growth in the long-term care insurance market. While his organization supports efforts to increase public awareness of the need to plan for the future, long-term care insurance is not affordable for many. There will always be a need for the safety-net services that Medicaid provides, and long-term care insurance promotion is not a panacea for the state's larger fiscal challenges.

7.8 Texas Association of Home Care

Anita Bradberry, Executive Director, provided testimony on March 13 and on May 1 regarding the committee's second charge. Ms. Bradberry underscored the importance of community care providers and, specifically, the PHC program, as attendant care is the most cost-effective and basic service needed by the population served through Medicaid-funded long-term care programs.

Despite the importance and cost-effectiveness of attendant care, reimbursement rates for these services are not competitive. Texas ranks last among all states in personal care attendant rates, which have risen only 8 percent over the past 11 years. What's more most attendants must travel to serve their clients and are not reimbursed for gasoline, the price of which has increased 150 percent since 2003.

To address the issues outlined above specifically and to improve the quality of long-term care generally, Ms. Bradberry's testimony included the following recommendations:

- In order to ensure an adequate workforce to meet the demand for community-based care, fully fund providers according to their respective rate methodologies, and include the impact of minimum wage increases and inflationary pressures;
- Make community care an equal opportunity choice through expansion of MFP;
- Establish the PHC program as the core for community-based long-term care, and use waiver services to wrap around state plan services;
- Utilize risk-based criteria to prioritize waiver services;
- Ensure that reimbursement rates for community services recognize case mix, complexity of care, and other available caregiver supports;
- Consolidate waivers administratively; and
- Eliminate unnecessary program-specific standards, contract administration, and reporting to caseworkers, in addition to other regulatory improvements.

7.9 Texas Senior Advocacy Coalition
David Thomason, member, provided testimony on March 13 and May 1 in favor of increased mobility and transportation options for seniors, growth in affordable senior housing, and background checks in all long term care facilities.

7.10 Texas Association of Homes and Services for the Aging
On both March 13 and May 1, George Linial, President/CEO, provided testimony regarding the committee's second charge. Mr. Linial's testimony included the following recommendations:

- Fully fund the direct care staffing enhancement program;
- Fully fund Medicaid reimbursement;
- Fund innovative programs, such as PACE;
- Consider the implementation of pay-for-performance programs;
- Continue to address workforce shortages;
- Advance the use of innovative technology; and
- Avoid relying on long-term care insurance as a cure-all.

Additionally, Mr. Linial expressed opposition to the implementation of a quality assurance fee as a way to fund nursing facilities adequately.

7.11 University of Texas Medical School at Houston
Dr. Carmel Bitondo Dyer, Director of the Geriatric and Palliative Division and Chief of Geriatrics at LBJ Hospital, provided written testimony on March 13 regarding the impact

of elder maltreatment. Dr. Dyer pointed out that clients seen by Adult Protective Services (APS) are often frail with multiple, serious chronic medical conditions. Studies demonstrate that elder maltreatment increases the risk of death three-fold. APS workers, health professionals and policy makers should use research and evidence to guide their work on behalf of older Texans.

7.12 Texas Partners for Adult Protective Services

Dr. Bruce C. Davis, Chairman, testified on March 13 regarding the impact of APS caseworkers on the safety and independence of older adults. In many cases elderly individuals are able to maintain themselves safely in their own homes with the assistance of an APS caseworker and the resources they bring to that person's aid.

Dr. Davis also underscored the impact of inflationary pressures on the senior community. Costs for items on which elderly Texans expend the majority of their incomes (e.g., food, fuel, and medication) are between 30 and 40 percent higher than they were this time last year. This crisis is currently felt by the neediest and will have an impact on those with greater resources in the coming months.

7.13 Oklahoma Health Care Authority

Mike Fogarty, CEO, provided testimony on May 1 regarding the Focus on Excellence initiative implemented in 2006 in Oklahoma. This initiative includes a value-based purchasing model, provider improvement, and better consumer information.

Participating facilities contribute data to measure ten quality indicators: quality of life; resident/family satisfaction; employee satisfaction; system-wide culture change; CNA turnover and retention; nurse turnover and retention; clinical measures; state survey compliance; occupancy and Medicare utilization; and nursing staff per patient day. Results are posted on a user-friendly consumer website. Facilities receive a 1 percent rate increase to participate and bonuses of up to 4 percent based on performance. The majority of Oklahoma's nursing facilities have elected to participate in the program.

7.14 Texas Silver-Haired Legislature

Chris Kyker, Speaker, provided testimony on May 1 on behalf of the Texas Silver-Haired Legislature. Ms. Kyker recommended that health care providers be trained in geriatrics and gerontology. She urged the 81st Texas Legislature to establish a task force on geriatric and gerontology education to research current criteria and policy for graduation from Texas medical schools and other health care schools. This task force should be charged with developing criteria and policy for the future education and training of health care professionals.

7.15 Health Air and Keep Austin Mobile

James Havis, Administrative Director, provided testimony on May 1 regarding the importance of transportation supports for aging Texans. His organization provides 400 rides every week, but many counties lack door-to-door transportation options for seniors. Mr. Havis also described his agency's efforts to procure a grant to convert 45 vehicles to bio-diesel engines.

7.16 Texas Association of Area Agencies on Aging
Doni Van Ryswyk, President, provided testimony on May 1 regarding her organization's proposed Medicaid diversion plan. In order to stem the rising tide of Medicaid outlays, Texas should explore strategies to make more efficient use of program dollars for Texans who require immediate help. Ms. Van Ryswyk proposed an innovative approach that relies on options counseling and service navigation. She advised that a system with a single point of entry will result in improved access to care in the least restrictive setting, greater consumer satisfaction with long-term supports and services, and a reduction in Medicaid outlays.

7.17 Coalition of Texans with Disabilities
On May 1, Dennis Borel, Executive Director, provided testimony regarding the long-term care workforce and efforts to protect the civil rights of persons with disabilities through the expansion of community-based services. Mr. Borel presented the following recommendations:

- Eliminate all interest lists within eight years;
- Fully fund rate methodologies;
- Fully fund the impact of minimum wage increases;
- Waive the state's sovereign immunity to the Americans with Disabilities Act and the Rehabilitation Act;
- Fully fund community-based services for the Promoting Independence Priority Populations;
- Develop and implement a Medicaid buy-in program for children with disabilites and persons on Medicaid waivers; and
- Provide funding for three additional CILs.

7.18 Nacogdoches Treatment Center
Kathy Strong, Mary Anne Oglesby, and Stephen Crain provided testimony on May 1 regarding day programs to serve patients with Alzheimer's. Specialized Alzheimer's treatment can delay the necessity for nursing home placement.

7.19 Rural Transit Districts
Three rural transit district representatives provided testimony on May 1 regarding the role of transportation in supporting independent living among the aging population: Vasteen Olier, Executive Director of Colorado Valley Transit; Edna Johnson, Director of Community Relations for the Capital Area Rural Transportation System; and Lyle Nelson, Vice President of Regional Planning and Operations for the Brazos Valley Transit District.

Rural transit districts provide a critical service to the aging population, particularly with regard to medical transportation. Many rural counties have no hospital and limited number of doctors, and the public transportation provided by rural transit districts may be the only way that seniors who are aging in place can access medical care. What's more, a robust public transportation system would have a positive impact on the direct service

workforce by helping home health workers in rural areas reach their clients.

Despite the importance of transportation, rural transit decades have not received increased funding to serve the aging population in more than two decades. Ms. Olier, Ms. Johnson, and Mr. Nelson also underscored the need for improved coordination with HHSC.

7.20 Rest Assured, LLC

Dustin Wright, General Manager, provided testimony on May 1 relating to his company's long-term care services and support system. Rest Assured provides a real-time, interactive support system using smart home technology to monitor individuals in community-based settings, increase accountability, relieve direct service staff, and minimize the need to travel.

7.21 Other Public Testimony

In addition to testimony provided on behalf of organizations serving the aging population, a number of individuals addressed concerns to the committee at both the March 13 and May 1 hearings. Their testimony is summarized below.

On March 13, Sam Perlin, advocate, encouraged the committee to focus on quality control in the nursing home industry to eliminate the "bad apples," improving transparency in the reimbursement process, and placing more emphasis on nursing home management and administrative turnover.

Ellen McDonald, a registered nurse, spoke to the impact of falls and dementia on the elderly population, as well as to problems that arise when family members are not able to take leave from work to care for their aging loved ones.

Carolyn Mounce, a nursing home ombudsman, highlighted the barriers to voting that some nursing home residents face, including lack of transportation and picture identification.

Winston Dollahon, a nursing facility administrator, indicated that cost-shifting is a common strategy among nursing facilities to mitigate the impact of low Medicaid reimbursement rates and expressed opposition to a quality assurance fee.

On May 1, numerous home health administrators highlighted the challenges posed by low reimbursement rates, including the recruitment and retention of a qualified workforce and staffing rural communities despite rising gas prices.

8. List of Acronyms

AAA	Area Agency on Aging
ADL	Activity of Daily Living
ADRC	Aging and Disability Resource Center
ALF	Assisted Living Facility
APS	Adult Protective Services
CAS	Community Attendant Services
CBA	Community-Based Alternatives
CIL	Center for Independent Living
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nursing Assistant
CWP	Consolidated Waiver Program
DADS	Department of Aging and Disability Services
DAHS	Day Activity and Health Services
DARS	Department of Assistive and Rehabilitative Services
DRA	Deficit Reduction Act
DSW	Direct Service Worker
FPL	Federal Poverty Level
GR	General Revenue
HHSC	Health and Human Services Commission
HMO	Health Maintenance Operation
ICF	Intermediate Care Facility
IHFS	In-Home and Family Support [program]
ISP	Individualized Service Plan
MAO	Medical Assistance Only
MEPD	Medicaid for the Elderly and People with Disabilities
MFP	Money Follows the Person
OAA	Older Americans Act
OBRA	Omnibus Budget Reconciliation Act
PACE	Program of All-Inclusive Care for the Elderly
PHC	Primary Home Care

RUG	Resource Utilization Group
SMI	State Median Income
SSI	Supplemental Security Income
TDHCA	Texas Department of Housing and Community Affairs
TDI	Texas Department of Insurance
TEA	Texas Education Agency
TIERS	Texas Integrated Eligibility Redesign System
TWC	Texas Workforce Commission
TXDOT	Texas Department of Transportation

9. Notes

[1] Olmstead v. L.C., 527 U.S. 581 (1999).
[2] Kaiser Commission on Medicaid and the Uninsured. (2007). *Medicaid and long-term care services and supports.* Washington, D.C.
[3] National Academy on an Aging Society. (2000). *Alzheimer's disease and dementia: A growing challenge.* Washington, D.C.
[4] Texas Department on Aging. (2003). *Texas demographics: Older adults in Texas.* Austin, TX.
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[6] Texas Department on Aging, *Texas demographics.*
[7] Ibid.
[8] Texas Direct Service Workforce Initiative. (2008). *Stakeholder recommendations to improve recruitment, retention, and the perceived status of paraprofessional direct service workers in Texas.* Austin, TX: Luke, E.L.
[9] Ibid.
[10] Ibid.
[11] Based on a survey conducted by BDO Seidman, LLP.
[12] Based on a comparison of nursing home cost reports submitted to HHSC and audited by the Inspector General with reimbursement rates approved by the Texas Legislature.
[13] Texas Health and Human Services Commission. (2008). *Rate analysis for long-term care services.* Retrieved September 8, 2008, from http://www.hhsc.state.tx.us/medicaid/programs/rad/LtcSvs.html.
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[16] Aging Texas Well. *Transportation.* Austin, TX.
[17] U.S. Department of Health an Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Retrieved August 28, 2008, from http://www.surgeongeneral.gov/ library/ mentalhealth/chapter5/sec3.html.
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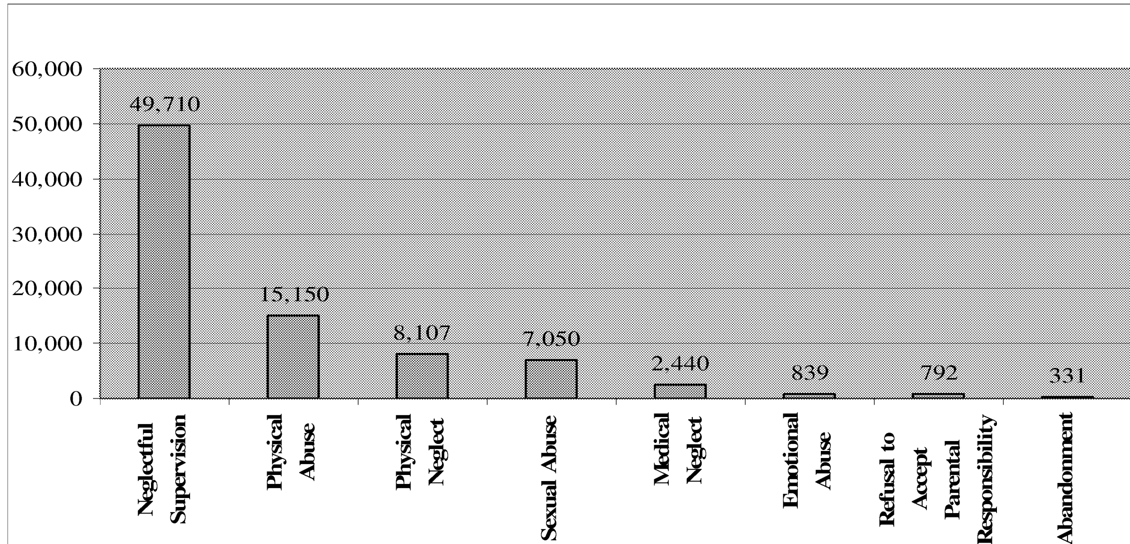
CHARGE 3
Evaluate Prevention and Early Intervention programs at the Department of Family and Protective Services that have been funded by the Texas Legislature for the prevention of child abuse and neglect. Consider if higher priority for selection should be given to child or family mentoring or other support services, such as foster grandparents and efforts that assist mothers.

1. Child Abuse and Neglect in Texas
Chapter 261 of Texas' Family Code defines in detail acts that constitute child abuse and neglect. Broadly, this definition includes physical, sexual, and emotional abuse, abandonment, medical and physical neglect, as well as neglectful supervision.

In FY 2007, the Texas Department of Family and Protective Services (DFPS) received reports of abuse and neglect involving 278,303 children and ultimately confirmed that 71,344 of these children were victims. Statewide, approximately 11 of every 1,000 children are confirmed victims of abuse or neglect,[1] a rate slightly lower than the national average. It is important to note, however, that the rate of confirmed victims may not be comparable across states, as local and state policies affect what may be defined as abuse or neglect, as well as how allegations are reported, investigated, and confirmed. What's more, the number of confirmed victims likely underestimates the true prevalence of child maltreatment in the state and nation.

Figure 3.1 Confirmed Cases of Abuse and Neglect, FY 2007



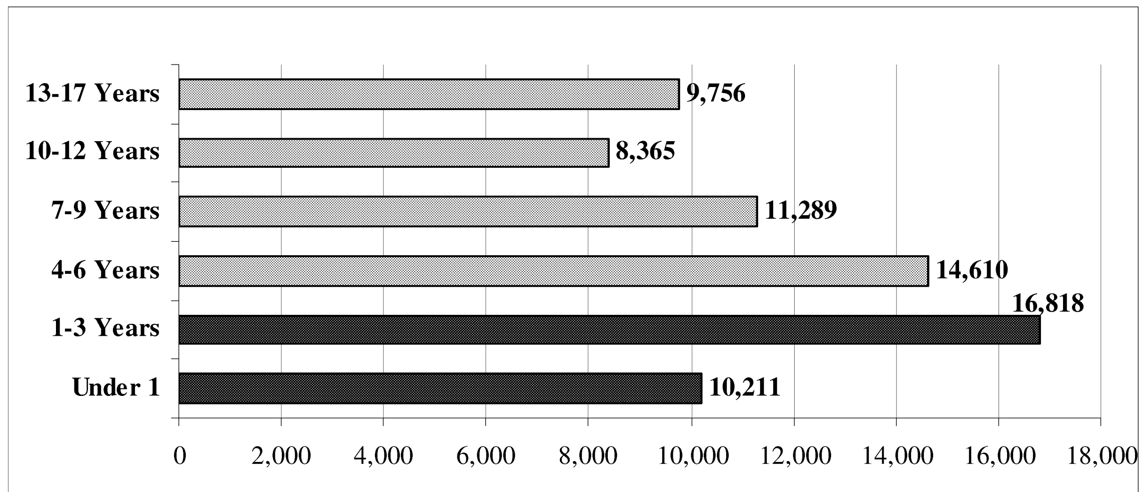
Source: Texas Department of Family and Protective Services[2]

Statistics reported annually by DFPS indicate that neglectful supervision is the most likely finding in a confirmed investigation, accounting for nearly 60 percent of all confirmed abuse and neglect cases in FY 2007 (Figure 3.1). Sexual abuse made up under 10 percent of confirmed cases statewide, but evidence suggests that it is highly underreported. In fact, it is estimated that one in four girls and one in six boys will become the victim of sexual abuse before the age of 18.[3]

1.1 Impact of Abuse and Neglect
The impact of child maltreatment in Texas is felt by children, families, local and state governments, and society at large. Aside from the initial physical and emotional trauma, child victims of abuse and neglect are more likely to experience developmental delays and cognitive impairments that, in turn, impede academic performance, health, and productivity later in life.[4]

Recent research indicates that child abuse and neglect actually alter the natural process of brain development.[5] According to research, opportunities for remedial intervention in the case of child abuse or neglect in the early years are highly time-sensitive.[6] This is of particular concern given the age distribution of children who experience child maltreatment. In Texas, more than 10,000 confirmed abuse and neglect victims in FY 2007 were infants (14 percent), and almost 40 percent of victims were between the ages of zero and three (Figure 3.2).

Figure 3.2 Age of Confirmed Victims of Abuse and Neglect, FY 2007



Source: Texas Department of Family and Protective Services

The long-term negative impact of sexual abuse on victims, 90 percent of whom know their abuser, are numerous. Victims of sexual abuse are more likely than their non-abused peers to struggle with substance abuse and mental illness, attempt suicide, have an eating disorder, and engage in risky sexual behavior.[7] The effects of childhood sexual abuse are felt into adulthood and even have ramifications for future generations. In fact, 60 percent of first-time teenage pregnancies follow incidences of molestation, rape, or attempted rape, and women who report having experienced childhood rape are three times as likely as their non-abused peers to become pregnant before the age of 18.[8]

The annual fiscal impact of child abuse nationwide is estimated at $104 billion. Direct costs include hospitalization, mental health services, child welfare services, and law enforcement, totaling more than $33 billion. Indirect costs are estimated at $71 billion and include expenditures related to special education, juvenile delinquency, mental and medical health care, and adult involvement in the criminal justice system.[9]

Approximately $11 billion of these direct and indirect costs may be attributable to children living in Texas,*[10] of which a substantial portion is subsidized by state and local governments. Consequently, there is significant legislative interest in minimizing the potentially avoidable costs of abuse and neglect.

2. Defining Prevention

While child abuse and neglect may not immediately come to mind as a public health issue, they have a pronounced impact on the public health system and on the long-term health and well-being of children. Recognizing this impact, the United States Department of Health and Human Services' *Healthy People 2000* report identified the prevention of child abuse and neglect as a necessary public health goal.[11]

Policy makers and the public are accustomed to discussing traditional public health issues (e.g., cancer, heart disease, and HIV/AIDS) in terms of risk and protective factors. For example, it is widely recognized that obesity, smoking, and a sedentary lifestyle are risk factors for heart disease, while regular exercise and a healthy diet protect against the incidence of heart disease. Disease prevention programs seek either to prevent the onset of a disease or to intervene early before it causes permanent damage by minimizing risk factors and maximizing protective factors. Effective prevention programs have the potential to improve health outcomes for recipients and reduce outlays for acute and palliative care.

Similarly, child abuse prevention programs seek either to provide services before abuse or neglect occurs, or to intervene early, before maltreatment becomes severe and/or chronic. Research has identified correlations between certain risk factors and the incidence of child abuse and neglect, as well as protective factors that, when present, reduce the likelihood that maltreatment will occur. Substance abuse, mental illness, poverty, and domestic violence are recognized risk factors for child abuse and neglect. Conversely, extended family support, parental coping skills, knowledge of child development, as well as access to health care, social services, and adequate housing are commonly recognized as factors that protect against the occurrence of child abuse and neglect.[12] Broadly defined, prevention programs target children in families where abuse and neglect are likely to occur (e.g., families with multiple risk factors) in an effort both to reduce risk factors and to promote the development of protective factors in their stead.

Prevention programs are typically categorized along a continuum according to when the initial intervention is likely to occur:

- **Primary** prevention activities (sometimes referred to as "universal") are directed at the population at large to stop maltreatment before it ever occurs. Activities may include public awareness campaigns and distribution of educational materials;
- **Secondary** prevention activities target families in high-risk populations to reduce the incidence of abuse and neglect. Activities may include parent education

* Based on FY 2006 data from ACF and DFPS indicating that 11 percent of confirmed victims of child maltreatment nationwide live in Texas.

programs, home visitation programs, respite services, and financial support for those families where poverty is a significant risk factor; and

- **Tertiary** prevention activities target the families of children who are confirmed victims of abuse or neglect in an effort to minimize negative impact and prevent reoccurrence. Activities may include intensive family preservation services, counseling by mental health professionals, and parent mentorship programs.[13]

Some programs may provide activities that fall within more than one category, but these basic distinctions are useful in framing policy decisions. Texas' Prevention and Early Intervention (PEI) division offers services in each of these categories, using a slightly different terminology. "Universal" services correspond to primary prevention activities, while "selective" and "indicated" services fall within the category of secondary prevention activities.[14]

2.1 Efficacy of Prevention

It is unlikely that any prevention program will completely eliminate the problem it is targeting, whether diabetes, substance abuse, or child maltreatment. There is evidence, however, that prevention programs receiving sustained attention and resources can have a positive effect and reduce direct and indirect costs in the middle and long run. In a 2003 report on emerging prevention practices, the Children's Bureau Office on Child Abuse and Neglect highlighted a number of effective prevention campaigns, including the following:

- Concerted efforts to prevent alcohol-related traffic deaths through public awareness campaigns have contributed to a 30 percent reduction in total fatalities over the past two decades;
- HIV transmission prevention efforts contributed to a 66 percent reduction in perinatally acquired AIDS cases in the United States between 1992 and 1997, resulting in a net savings of $38 million in health care costs alone;
- Prevention and education programs have helped to maintain the downward trend in adolescent pregnancy that began in the early 1990s, as well as an overall decline in the abortion rate for adolescents; and
- Substantial decreases from 1993 to 2000 in smoking prevalence are due, in part, to prevention efforts, including education, support services for quitters, and policy changes.[15]

Each of these prevention efforts had in common the sustained financial support and attention of lawmakers, implementing agencies, and the public. It is reasonable to assert that child abuse prevention could be just as successful under similar conditions, benefitting Texas' children and taxpayers alike.

2.2 Evaluation

While numerous studies have indicated the need for greater investment in preventive efforts, and others have demonstrated significant return on investment, not all child abuse and neglect prevention programs are equally effective. State, local, and non-governmental entities that fund prevention efforts have focused in recent years on the

most effective way to assess a program's potential to reduce the incidence of child maltreatment.

To ensure that the state's resources are directed towards successful prevention efforts, the Legislature and DFPS have taken measures to use demonstrated program efficacy as a condition for funding. PEI currently uses a four-tiered, evidence-based classification system, developed collaboratively with the United States Department of Health and Human Services' Administration for Children and Families (ACF), to assess the potential efficacy of competing programs.

According to this framework, programs at all levels have certain characteristics in common. For example, every program should be able to articulate a theory of change, specify clearly defined outcomes, and describe activities designed to achieve those outcomes. Additionally, there should be no evidence or basis for assuming that the practice may present a substantial risk of harm to those who receive it. Distinctions among the four levels are generally made according to the level of evaluative rigor to which the program has been subjected. Appendix F includes greater detail regarding these levels. In highly general terms, however, they may be differentiated as follows:

- **Emerging and Evidence-Informed Programs and Practices (Level I)** may have undergone limited evaluation or be in the evaluation process;
- **Promising Programs and Practices (Level II)** have undergone at least one study using a control or comparison group establishing efficacy;
- **Supported and Efficacious Programs and Practices (Level III)** have undergone at least two rigorous, randomized control trials demonstrating efficacy; and
- **Well-Supported and Effective Programs and Practices (Level IV)** have undergone at least two rigorous, randomized control trials demonstrating efficacy and have been replicated in multiple sites.

Evidence-based programs often emphasize that, if a program replicates their model and expects to achieve the same outcomes, strict adherence to each element of the model is necessary. For example, the Nurse Family Partnership (NFP), a home visitation program that was funded by the 80th Legislature for replication in Texas, employs registered nurses to visit at-risk mothers in their homes and has demonstrated effectiveness and a healthy return on investment in numerous trials. It would be much less costly to recruit licensed social workers for this purpose, but it is not certain that the program would achieve the same results. On the other hand, effective home-visitation programs exist throughout the state that adhere to other models with less substantial evidence bases. A healthy dialogue continues regarding the degree to which it is practical and affordable to replicate evidence-based programs, including the inevitable trade-offs between model fidelity and program cost.

3. Texas' Division of Prevention and Early Intervention

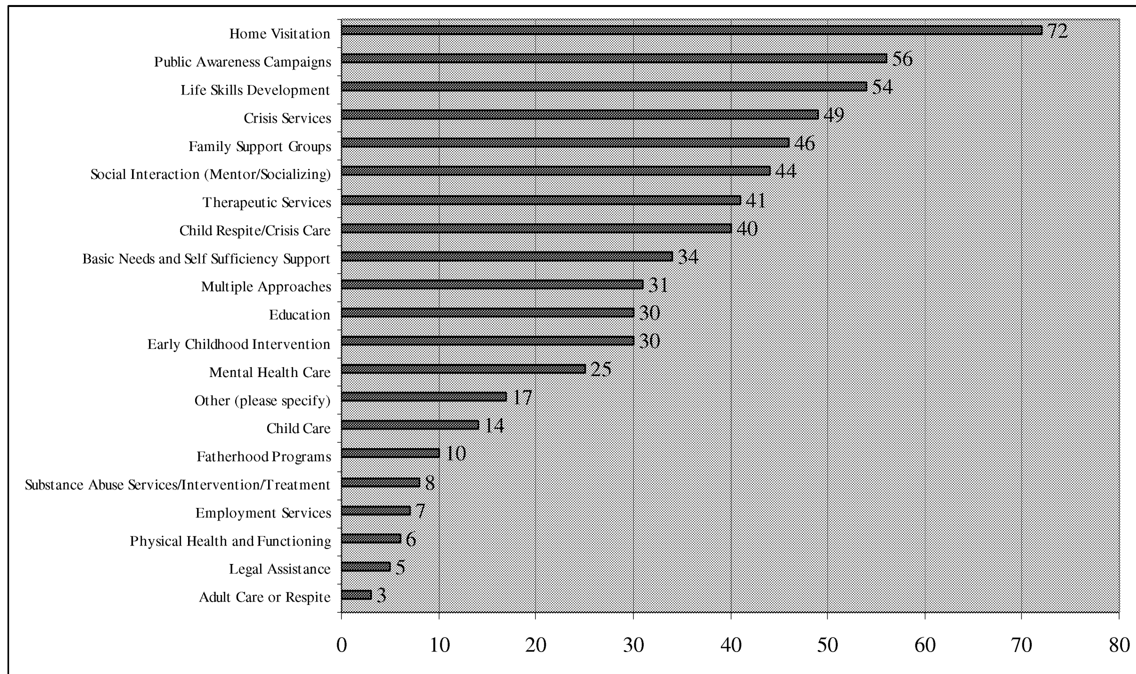
In 1999, the 76th Legislature approved Senate Bill 1574, consolidating prevention and early intervention services across several state agencies into a new PEI division under the

then Department of Protective and Regulatory Services (PRS). In January 2003, the 78th Legislature passed House Bill 2292, which dramatically restructured Texas' health and human services agencies. Pursuant to this legislation, PRS was renamed DFPS. In addition, administration of the Communities in Schools (CIS) program was transferred to the Texas Education Agency (TEA).

3.1 Programs

Currently, PEI contracts with community-based organizations to administer services that aim to prevent child abuse and neglect, as well as juvenile delinquency and truancy.* Three programs specifically target child abuse and neglect prevention, and one addresses both maltreatment and delinquency. Additionally, PEI operates a hotline for runaways and several programs funded through budget riders. Because PEI works with community-based organizations, services vary significantly from county to county and program to program, but services such as home visitation, public awareness, and skills development are common (Figure 3.3).

Figure 3.3 Number of Prevention Programs Offering Specific Services by Type



Source: The Interagency Coordinating Council for Building Healthy Families[16]

3.1.1 Community-Based Child Abuse Prevention

The Community-Based Child Abuse Prevention (CBCAP) program seeks to prevent child abuse and neglect by encouraging parental involvement and use of existing services. The model places a high priority on community engagement, and recipients can tailor the program to meet their community's needs. Programs funded through a CBCAP grant

* While technically outside the scope of this report, PEI administers two programs to prevent juvenile delinquency, the Community Youth Development (CYD) program and the Youth Resiliency Program (YR). CYD served more than 12,000 youths in 15 targeted ZIP codes in FY 2007 at a cost of $6.5 million. The YR program received $2.9 million to serve 3,338 youths in 12 counties.

offer a diverse array of services that vary widely across the state. Many but not all include home visitation services, parent education and training, and other ancillary services (Table 3.1).

In FY 2007, PEI administered approximately $700,000 in federal CBCAP grant funding to seven sites, serving 960 families across 15 counties. Other funds appropriated to the CBCAP strategy are used to provide program support (e.g., administration, overhead, and staff), hold an annual provider conference, publish the agency's annual parenting calendar, and conduct outreach and awareness efforts.

Table 3.1 Prevention Programs Receiving CBCAP Funding, FY 2008

Contractor	Prevention Program Model	Available Services Include	Counties Served
The Children's Advocacy Center of Tom Green County	Nurturing Parenting Program & Parents Anonymous	Home visitation, parent education and training, support groups, parent mentorship	Coke, Concho, Crockett, Irion, Reagan, Schleicher, Sterling, Sutton, Tom Green, Runnells
Parkland Memorial Hospital	Parents Anonymous	Home visitation, parent education & training, support groups, domestic violence classes	Dallas
Family Connections	CALMS, a Guide to Soothing Your Baby, & Parenting Counts	Parent mentoring, home visitation, parent education and training	Travis
Greater Port Arthur Chamber of Commerce	Parenting Wisely	Parent education classes using the Parenting Wisely Curriculum	Jefferson
Family Services Association of San Antonio	Parents as Teachers	Rural Family Support Program offers home visitation using the Parents as Teachers Curriculum	Bexar
Relief Nursery of Collin County	Relief Nursery of Oregon	Outreach connection, therapeutic early childhood services, parent education, mental health services, substance abuse recovery support, parent resource room	Collin
Relief Nursery of Central Texas	Relief Nursery of Oregon	Outreach connection, therapeutic early childhood services, parent education, mental health services, substance abuse recovery support, parent resource room	Travis

3.1.2 Family Strengthening

The Family Strengthening (FS) program works to increase family protective factors and resiliency with the ultimate goal of preventing child abuse and neglect. Programs are required to promote community collaboration and provide a continuum of services. As in CBCAP programs, services available through FS initiatives vary. In FY 2007, PEI administered approximately $2.3 million in federal and state funding to serve 1,347 families through 10 programs in 13 counties (Table 3.2).

Table 3.2 Prevention Programs Receiving FS, FY 2008

Contractor	Prevention Program Model	Available Services Include	Counties Served
AVANCE	AVANCE Parent Child Education Program	Child school readiness, home visitation, parent education and training, resource and referral, child care, transportation	Hidalgo
AVANCE	AVANCE Parent Child Education Program	Child school readiness, home visitation, parent education and training, resource and referral, child care, transportation	Dallas
AVANCE	AVANCE Parent Child Education Program	Child school readiness, home visitation, parent education and training, resource and referral, child care, transportation	Cameron
Big Brothers Big Sisters of South Texas	BBBS Mentoring Program	mentoring, parent education, resource and referral	Bexar, Kerr, Nueces, Webb, Guadalupe, Comal
DePelchin Children's Center	University of Maryland's Family Connections	family and individual counseling, home visitation, parent education and training, support groups, resource and referral, basic needs support, child care, transportation	Harris
Family Care Connection	Parents as Teachers & Strengthening America's Families	home visitation, parent education and training, support groups, resource and referral, transportation	Dallas
New Horizons Ranch & Center	Parents as Teachers & University of Maryland's Family Connections	family and individual counseling, home visitation, parent education and training, mentoring, emergency care, support groups, resource and referral, child care, transportation	Taylor
The Children's Shelter	Healthy Families America & Nurturing Parenting Program	fatherhood services, home visitation, parent education and training, support groups, resource and referral, basic needs support, child care, transportation	Bexar, Atascosa
The Parenting Center	Healthy Families America	home visitation, parent education and training, resource and referral, transportation	Tarrant
YWCA of Metropolitan Dallas	Nurse Family Partnership	fatherhood services, home visitation, mentoring, parent education and training, resource and referral, basic needs support	Dallas

3.1.3 Texas Families: Together and Safe

The Texas Families Together and Safe (TFTS) program seeks to alleviate stress and promote parental competencies in order to prevent abuse and neglect. Related goals include developing and supporting community-based supports, improving collaboration at the community level, and helping children to remain in their homes. TFTS funds are specifically targeted towards families with multiple risk factors for child maltreatment. In FY 2007, PEI administered approximately $3.3 million in federal funding through eight contracts to serve 2,741 families across 30 counties (Table 3.3).

Table 3.3 Prevention Programs Receiving TFTS Funding, FY 2008

Contractor	Prevention Program Model	Available Services Include	Counties Served
AVANCE	AVANCE Parent Child Education Program	Child school readiness, home visitation, parent education and training, resource and referral, child care, transportation	Cameron, Hidalgo, Starr, Willacy
Catholic Charities Diocese of Fort Worth	Homebuilders (Parents & Children Together)	Family and individual counseling, home visitation, parent education and training, respite, resource and referral, basic needs support, transportation	Tarrant
DePelchin Children's Center	University of Maryland's Family Connections, STEP & Nurturing Parenting Program	family and individual counseling, home visitation, parent education and training, support groups, resource and referral, basic needs support, child care, transportation	Harris
Family Services Center	Active Parenting, STEP, Common Sense Parenting, Nurturing Parenting Program & Children in the Middle	family and individual counseling, home visitation, parent education and training, support groups, booster sessions, resource and referral, basic needs support, child care, transportation	Brown, Coleman, Comanche, Eastland, McCulloch, Mills, San Saba
Healthy Families San Angelo	Healthy Families America	child school readiness, home visitation, parent education, support groups, resource and referral	Tom Green
The Parenting Cottage	Parents as Teachers	school readiness, home visitation, mentoring, parent education and training, support groups, booster sessions, resource and referral, basic needs support	Lubbock, Crosby, Hale, Hockley, Garza, Lynn, Terry
United Way of San Antonio & Bexar County	Parents as Teachers & Nurturing Parenting Program	school readiness, home visitation, mentoring, parent education and training, support groups, booster sessions, resource and referral, basic needs support, transportation	Bexar, Uvalde, Zavala
Unity Partners dba Project Unity	University of Maryland's Family Connections	family, individual, and group counseling, home visitation, parent education and training, support groups, resource and referral, basic needs support, child care, transportation	Robertson, Leon, Grimes, Burleson, Brazos, Washington, Madison

3.1.4 Services to At-Risk Youth

The Services to At-Risk Youth (STAR) program addresses the prevention of both child

maltreatment and juvenile delinquency. STAR is the only program administered through PEI that is available in every one of Texas' 254 counties, and 87 percent of participating youth in FY 2007 continued to exhibit improved outcomes 90 days after they ceased to receive services. Youths are eligible for STAR if they experience conflict at home, truancy, delinquency, or if they have run away in the past. While services vary by provider, each family receives an individualized plan that may include counseling, respite, or other preventative services. In FY 2007, PEI administered 40 contracts to serve more than 32,000 youths for a total cost of approximately $20 million. Appendix G contains more information regarding each of the STAR contractors, areas served, and services offered.

3.1.5 Texas Youth and Runaway Hotline

The Texas Youth and Runaway Hotline provides crisis intervention and telephone counseling, information and referral, as well as other support services. The hotline is staffed 24 hours a day, mostly by volunteers. In FY 2007, 68 volunteer workers spent 4,011 hours to respond to more than 35,000 calls for a total cost of $177,280.

3.1.6 Tertiary Child Abuse Prevention

The Tertiary Child Abuse Prevention program has been funded through a small budget rider for more than a decade.* The program works to reduce child maltreatment and the number of families re-entering the child welfare system by targeting services to families with a CPS history. Currently, DFPS is in the procurement process for the tertiary prevention program. When it was last in operation in FY 2007, PEI served 59 families through one contract for $79,650. Services were available at that time in Andrews, Dawson, Howard, Midland, Reeves, Pecos, Ward, and Winkler counties, but the counties served may change once the procurement process is complete.

3.1.7 Additional Programs

The Legislature also required in Rider 32 of the DFPS budget for FY 2008-09 that funding be used to procure services for the Community-Based Family Services (CBFS) and Statewide Network of Youth Services (SNYS) programs. CBFS services will target prevention services to families with an investigations history, as well as those with low-risk, confirmed cases of abuse and neglect. The SNYS programs are intended to prevent juvenile delinquency.

3.2 Funding

In FY 2008, PEI appropriations totaled approximately $43.6 million, over 40 percent of which is federal, including Title IV-B funds and CBCAP grant money. Currently, these dollars are appropriated to DFPS to fund six separate budget strategies (Table 3.4).

Other PEI funding is appropriated primarily from GR and the Child Abuse and Neglect Prevention Operating Account, often referred to as the Children's Trust Fund (CTF). In 1985, the Legislature created this dedicated funding source to provide grants to community-based organizations for child abuse and neglect prevention programs. Currently, the CTF is supported by state marriage license fees.[17]

* DFPS Rider 6 in the 2006-07 appropriations bill.

Table 3.4 DFPS Budget Strategies for PEI

Strategy	*FY 2008 Approp. (in millions)*	*Programs*	*Funding by Source (in millions)*	
A.2.12 STAR PROGRAM	$21.0	Services to At-Risk Youth	State	$20.0
			Federal	$1.0
A.2.13 CYD PROGRAM	$7.8	Community Youth Development	State	$0.9
			Federal	$6.8
A.2.14 TEXAS FAMILIES PROGRAM	$4.1	Texas Families Together and Safe	State	NA
			Federal	$4.1
A.2.15 CHILD ABUSE PREVENTION GRANTS	$1.8	Community-Based Child Abuse Prevention (includes support services for this program)	State	NA
			Federal	$1.8
A.2.16 OTHER AT-RISK PREVENTION PROGRAMS	$7.0	Tertiary, Youth Resiliency, Community-Based Family Services, Statewide Network of Youth Services, Family Strengthening	State	$3.5
			Federal	$3.5
A.2.17 AT-RISK PREVENTION PROGRAM SUPPORT	$2.0	Texas Youth and Runaway Hotline & other support services	State	$0.7
			Federal	$1.3

Source: Based on Data from the FY 2008 Governor's Operating Budget

Funding for PEI has fluctuated substantially in recent years. In FY 2003, PEI administered 12 prevention and early intervention programs with a budget of $63 million. Funds were subsequently cut significantly in the 78th Legislative Session. While all health and human services agencies experienced budget reductions, PEI shouldered a disproportionate share of the burden. Even adjusting for CIS funding, which was transferred to TEA, PEI's budget was reduced by approximately $13 million, or 20 percent. As evidenced by Table 3.5, funding for prevention and early intervention programs at DFPS has been only partially restored over the past two biennia, yet the number of children and families involved in CPS cases has grown considerably.

Table 3.5 Annual State Appropriations for PEI

FY 2002-03	*FY 2004-05*		*FY 2005-06*	*FY 2007-08*
$63 million	Including CIS	Excluding CIS	$42 million	$43.6 million
	$50 million	$32 million		

Source: Texas Department of Family and Protective Services

3.3 Contract Monitoring

PEI employs 25 FTEs who perform contract management for prevention contracts. These employees participate in day-to-day program development, contract monitoring, billing, communication with contractors, and training and technical assistance. Formal, on-site monitoring is generally conducted between January and May of each fiscal year, and ongoing monitoring is conducted monthly.

DFPS monitors a contractor's performance under a client services contract to ensure

contractor compliance with applicable state and federal regulations, DFPS policies and procedures, and contract terms. The department requires that a contractor maintain sufficient records to account for the use of awarded funds and to provide reasonable evidence that service delivery complies with contract provisions.

Contract monitoring is based on an annual assessment designed to identify the risk of potential harm to clients, inadequate service provision, or misuse of resources. Upon completion of the review, a monitoring report, which is a formal document developed by the contract manager at the conclusion of the monitoring review, is issued to the contractor. This report identifies documents and communicates to the contractor the facts, findings, conclusions, and recommendations resulting from the review. Contractors are required to respond in writing to issues relating to contractual compliance cited in the report and to implement any mandatory corrective actions to return to compliance.

In addition to annual review, ongoing monitoring is conducted to assess progress toward meeting contract performance measures. This monitoring may include billing and/or performance reviews. Every month, contractors report the number of participants served. Client surveys must be conducted and reported quarterly, and participant outcomes (e.g. whether children remained safe) are reviewed biannually. Contractors are required to submit a corrective action plan if there is evidence that they are under-performing on any of these measures (Table 3.6).

3.6 Performance Measures for Child Abuse and Neglect Prevention

Output Measures		*Outcome Measures*	
Output	*Target*	*Outcome*	*Target*
Average number of families served monthly	Specified in contract	Increase in the average score of at least one protective factor is reported by families.	Negotiated after baseline data collected from primary caregivers
Number of families served over the fiscal year	Specified in contract	Increase of at least one protective factor is reported by individual families	Negotiated after baseline data collected from primary caregivers
Percentage of families served during the initial and any subsequent contract period	Negotiated after baseline data are collected	Percentage of families for whom a primary caregiver is not a perpetrator in a confirmed case of child abuse/ neglect while served by the program	100%
Completed pre-service Protective Factors Survey questionnaires	100%	Family satisfaction	80%
Completed post-service Protective Factors Survey questionnaires	80%		
Completed Prevention and Early Intervention Family Satisfaction Survey Questionnaires	50%		

Source: Texas Department of Family and Protective Services

4. Other Prevention Efforts

Prevention and early intervention efforts are not limited to DFPS, and numerous programs exist across agencies and even within the court system to address risk factors related to child maltreatment. Two particularly relevant efforts are described in greater

detail below.

4.1. Interagency Coordinating Council for Building Healthy Families

In response to a perceived lack of coordination among prevention and early intervention programs across agencies, the Interagency Coordinating Council for Building Healthy Families (ICC) was established in 2005 with the passage of HB 1685. This legislation directed ICC members from 11 state agencies to inventory Texas' existing prevention programs and provide recommendations to the 80th Texas Legislature regarding better cross-agency collaboration around prevention efforts. In their report, issued December 2006, the ICC made the following recommendations:

- Continue to support child maltreatment prevention and early intervention efforts delivered through state agencies, with the goal of achieving a sustained, long-term, cost-effective investment in Texas families;
- Consider implementation of a state-guided evaluation effort to assess the effectiveness of state-funded child maltreatment prevention programs and services to determine which current programs are achieving their intended outcomes and to support the movement of programs to higher levels of evidence-based practice, thus ensuring that funding is spent on programs with proven results; and
- Support the continuation of the ICC, to focus primarily on child abuse and neglect and secondarily on related state agency efforts that contribute to the development of healthy families.[18]

In the 80th Legislative Session, HB 662 reauthorized the ICC, charging it with two additional responsibilities. First, the ICC will consult with DFPS to develop a strategic plan for prevention of child abuse and neglect. Second, the ICC will evaluate prevention and early intervention programs, addressing efficacy and cost-effectiveness. The interim work of the House Committee on Human Services has been informed by draft versions of the strategic plan, the final version of which is due December 1, 2008. DFPS has contracted with the University of Houston to conduct an evaluation of child maltreatment programs. An initial report will be submitted to the Legislature by December 1, 2008, with a final version due by December 1, 2009.

4.2 Family Treatment Drug Courts

Between 40 and 80 percent of child abuse cases involve families with substance abuse histories.[19] Dealing with this underlying issue is a prerequisite to successful resolution of many abuse and neglect cases. Parents with substance abuse problems, however, face many barriers to regaining custody of their children. Waiting lists for treatment services are often long, and recidivism rates are high, even when a parent is able to access treatment. What's more, a parent may be navigating the criminal and family court systems simultaneously without any support.

In response to the prevalence of substance abuse among child welfare cases, some courts have adopted a family treatment drug court (FTDC) model to provide greater structure and accountability for both children and parents, with the goal of improving child welfare outcomes. As of April 2006, there were 283 FTDC sites either in operation or under

development in 43 states across the nation.[20] FTDCs are specialized drug courts that work with parents whose involvement in the child welfare system is the result of their substance abuse. Traditional family courts have had limited success in improving outcomes for families struggling with substance abuse, and the FTDC seeks to address families more holistically. Participants attend regular (usually weekly) hearings, receive intensive monitoring and substance abuse treatment, are subjected to frequent drug testing, and experience consistent application of rewards and sanctions based on compliance with the court's directives.

Drug courts across the country have demonstrated success in reducing recidivism,[21] increasing collaboration among judges, schools, providers, and other agencies, as well as minimizing duplication of services across agencies.[22] FTDCs have also undergone evaluation with promising results. Parents involved with FTDCs are significantly more likely than those in regular family courts to access substance abuse treatment services, and 40-54 percent more likely to actually complete treatment. Evidence suggests that reunification may take somewhat longer because of the intensiveness of FTDC services, but children who receive FTDC monitoring are significantly more likely to be reunified with their parent (usually the mother).[23]

FTDCs focus on families with open CPS cases and may be categorized as a tertiary prevention program that collaborates with but is not administered by DFPS. Currently, there are nine FTDCs in Texas serving Bexar, El Paso, Grayson, Harris, Jefferson, Smith, Tarrant, Tom Green (and surrounding counties), and Travis counties.[24]

4. Conclusion and Recommendations

Based on testimony provided by stakeholders and the public, the House Committee on Human Services makes the following recommendations:

1. **The Legislature and DFPS should direct available funding towards prevention and early intervention programs that support the following general goals:**

    a. Developing a continuum of preventive services that may be accessed at any phase in a child's development, from prenatal services for expectant mothers to intervention services for at-risk youth, focusing additional funding on filling critical gaps along that continuum;

    b. Treating families holistically;

    c. Developing adequate services to treat substance abuse;

    d. Promoting collaboration at the community level; and

    e. Addressing poverty as an underlying factor in many abuse and neglect cases.

2. **Recognizing the integral role of family courts in the child welfare system, the Legislature should provide additional funding to the judiciary with the purpose of developing FTDCs.**

3. **DFPS should include in its strategic planning process a specific strategy to address the prevention of sexual abuse.**

4. **The ICC should be sustained to support strategic collaboration at the agency level around the prevention of child abuse and neglect. Because the ICC has been charged with the difficult but necessary task of cross-program comparison, it should also consider developing recommendations regarding how prevention funding would be best distributed.**

5. **The Legislature should provide adequate funding to offer home-visitation services to mothers in at-risk families statewide.**

6. **The Legislature should support community outreach efforts that focus on connecting families with basic needs to appropriate state and local services.**

7. **DFPS should collaborate with transition centers and providers to improve sexual health training and knowledge among foster parents and youth with the specific goal of preventing pregnancy and breaking the long-term cycle of families entering the child welfare system.**

5. Testimony and Public Comment

The committee heard testimony on the third interim charge at two separate hearings (February 21, 2008, at the University of Texas at Arlington and April 3, 2008, at the Texas State Capitol in Austin). Testimony was provided by DFPS, stakeholder groups and the public at large. The following section summarizes public and written testimony received by the committee relating to the prevention of child abuse and neglect.

5.1 Department of Family and Protective Services

Joyce James, Assistant Commissioner of CPS, provided testimony on February 21 regarding local collaborations in Region 3 to address the prevention of child abuse and neglect. As Ms. James explained, most PEI efforts are locally driven, and DFPS contracts with community-based organizations and agencies to provide services tailored to the needs of that area.

Among local collaborations cited by Ms. James, the following were described in detail:

- A pilot project with Early Childhood Intervention on visitation practices with families;
- Support for the Child Abuse Prevention Coalition in its efforts to obtain grant funding to produce a video on sexual abuse; and
- Work with Dallas and Tarrant counties to develop additional drug courts.

On April 3, Jeannie Coale, Assistant Commissioner of Purchased Client Services, provided testimony related to prevention and early intervention programs funded through DFPS, including child maltreatment and juvenile delinquency prevention programs. For each individual program, Ms. Coale provided information regarding the number served and total cost (as presented in Section 3.1 of this report). The vast majority (90 percent) of primary caregivers receiving PEI services are female.

Ms. Coale also described the department's contract monitoring activities. PEI has 25 FTEs who perform contract management through on-site visits and desk review of required documentation. The focus of monitoring may be a program's ability to achieve results, fiscal review, or both.

5.2 Permanent Judicial Commission for Children, Youth, and Families

On February 21, Tina Amberboy, Executive Director of the Permanent Judicial Commission for Children, Youth, and Families, testified regarding the importance of earlier intervention and mediation. She emphasized that Family Team Meetings and Family Group Decision-Making are good models, but earlier intervention is needed is well. According to Ms. Amberboy, drug courts may provide a promising way to prevent recurrence of abuse by addressing the risk factor of substance abuse and helping families receive treatment.

5.3 Nurse Family Partnership

On February 21, Colleen Quinn, Program Developer for NFP, described the program, its evidence base, and recent efforts in Texas to implement the model. NFP seeks to

improve pregnancy outcomes, child health and development, and parents' economic self-sufficiency among low-income, first-time parents and their children through home visits from registered nurses. Across multiple trials, NFP has demonstrated a 50 percent reduction in incidents of abuse and neglect, and its return on investment is estimated at $5.70 per dollar dedicated to the program.

During the 80th Texas Legislature, the passage of SB 156 authorized the Health and Human Services Commission (HHSC) to provide grant funding to communities across the state to serve approximately 2,000 Medicaid-eligible families through the NFP program. The legislation requires that communities provide a local match and that grantees adhere to the evidence-based program model. In February 2008, HHSC hired a state nurse consultant to provide quality assurance and clinical consultation to Texas' NFP programs. Requests for proposals were issued in winter 2007, and contracts were awarded in early summer 2008. Services are scheduled to begin on September 1, 2008.

5.4 Relief Nursery of Collin County

Karen Marx, Interim Director of the Relief Nursery of Collin County, provided testimony on February 21 regarding a nationally recognized "one-stop shop" model proven to strengthen at-risk families and prevent abuse or intervene before abuse becomes severe. The Relief Nursery model was developed in Oregon and is being funded in two locations by DFPS through CBCAP federal grant funds and local match. Ms. Marx testified that the program has an 80 percent success rate. One Relief Nursery will be located in Collin County. The other, Relief Nursery of Central Texas, will operate in Austin.

5.5 All Church Home for Children

Alan Schonborn, Vice President of Community Services, provided testimony on February 21 regarding the STAR program. STAR programs vary widely between rural and urban areas, are available in each of Texas' 254 counties, and are not intended for youth with open CPS cases. Mr. Schonborn described the program as highly effective and explained that DFPS measures results as part of their contract with community-based organizations like All Church Home.

5.6 Alliance for Children

Nancy Hagan, Executive Director of the Alliance for Children, provided written testimony regarding the prevention of child sexual abuse. In Texas in 2006, there were 67,737 confirmed reports of child abuse, 7,176 of which involved child sexual abuse. As awareness of sexual abuse grows, prevention has become an increasing focus of Texas' children's advocacy centers (CACs). The Alliance for Children supports a diverse approach to child sexual abuse prevention training and funds three research-based programs in the Fort Worth area:

- PS It's My Body!, a personal safety program for young children to learn how to recognize, resist, and report sexual abuse;
- Stewards of Children, an education program that teaches adults how to keep children safe from sexual predators; and

- NetSmartz, an online safety program to teach elementary, junior high, and high school students how to protect themselves from sexual predators on the internet.

5.7 Texas Association for the Protection of Children
Madeline McClure, Executive Director, provided testimony on April 3 relating to the importance of prevention and early intervention efforts. Ms. McClure underscored that the prevalence of child abuse and neglect is high and has disastrous consequences. In FY 2007 alone, 233 Texas children died from abuse and neglect.

Ms. McClure also itemized numerous costs associated with child abuse and neglect. Abused children are more likely to commit crimes, abuse substances, and are six times more likely to abuse their own children than are their non-abused peers. Based on national data, TexProtects estimates that child abuse cost Texas $2.4 billion in FY 2007, yet funding for child abuse prevention programs makes up less than 1 percent of the budget allocated for responding to abuse and neglect after they occur ($10.3 million per year versus $1.1 billion per year).

Ms. McClure presented a prevention strategy developed by her organization and made the following recommendations:

- Intervene early;
- Use best practices;
- Invest in evidence-based programs;
- Support program evaluation;
- Develop a continuum of services to serve children from pregnancy through high school;
- Include sexual abuse prevention as a separate strategy; and
- Invest more in programs that provide a greater return on investment.

5.8 Judge Darlene Byrne
On April 3, Judge Darlene Byrne, presiding judge for Travis County's 126th Judicial District Civil Court, provided testimony regarding the potential for drug courts to reduce the amount of time a child spends in care and prevent re-entry into the system. Judge Byrne recently received a grant to implement a FTDC in Travis County. Travis County received a federal grant of $2.5 million over five years ($500,000 per year to serve 20 families annually). This drug court is currently undergoing extensive evaluation, but Judge Byrne described the preliminary results as highly encouraging.

5.9 Relief Nursery of Central Texas
Jim Hine, Board Chair, provided testimony on April 3 regarding the Relief Nursery prevention model and its replication in central Texas. This model serves families with children up to five years of age with a set of comprehensive services tailored to a family's individual needs.

The Relief Nursery Model provides services specifically to address the presence of the following risk factors known to increase the likelihood of child maltreatment:

- Parental conflict or domestic violence;
- Substance abuse;
- Social isolation and/or lack of caregiver support;
- Inadequate child development knowledge;
- Ineffective parenting skills; and
- Parents of children with disabilities.

In its original implementation in Eugene, Oregon, the Relief Nursery model was demonstrated to reduce child abuse and entry into foster care. While 55 percent of families receiving services had a CPS history, less than 5 percent received any reports of child maltreatment after receiving services in the model. Additionally, 97 percent of children served require no foster parent support.

The model also seeks to increase the presence of the following protective factors:

- Available support in times of need;
- Nurturing and attachment;
- Effective problem-solving and communication skills; and
- Knowledge of child development and parenting.

As a result, the Relief Nursery promotes healthy development for children and a clean and sober lifestyle for parents. Among participating children, 90 percent are at age-appropriate development levels. What's more, 85 percent of parents with a history of substance abuse who participate in alcohol and drug recovery support services remain sober 17 months after treatment.

5.10 Texas Network of Youth Services

On April 3, Theresa Tod, Executive Director, provided testimony relating to prevention programs in general and Texas' STAR program in particular. Ms. Tod advocated for a comprehensive strategy at the community level to provide prevention services at any point in the life cycle and reminded the committee that prevention programs administered by DFPS do not represent the full array of existing programs that have an impact on child abuse.

Ms. Tod has worked closely with the STAR program since its inception in the early 1980s and noted how many essential services are delivered through this program alone. According to Ms. Tod, support for STAR should be maintained and even expanded. She highlighted the fact that, because STAR is a dual-purpose program, it is not being evaluated by the ICC and recommended that it undergo evaluation.

Finally, Ms. Tod cautioned that the evidence-based "seal of approval" is not always as clear a distinction as one might think, as the currently available evidence base is sometimes contradictory. What's more, it is important to recognize that requiring adoption of evidence-based models will introduce new costs, which will require higher funding levels or a reduction in the number of children and families served.

5.11 Mental Health America of Texas
Mary Ellen Nudd, Vice President, provided testimony on April 3 relating to the Parents as Teachers (PAT) program. PAT is an education and family support program that serves families from pregnancy until a child enters kindergarten. It is currently replicated in all 50 states and internationally in seven countries.

Before the 2003 cuts that severely reduced the PEI budget, PAT had its own budget strategy in the prevention and early intervention continuum. Currently, it is funded through various strategies in different communities and serves 6,000 children across the state.

Ms. Nudd pointed out that intervention is most effective in the early years and encouraged that funding be increased for this evidence-based model, pointing to its ability to improve parenting skills and increase school readiness.

5.12 Parents as Teachers
Nettie Cernosek, a parent educator for the Schulenberg/Weimar Area PAT program, provided written testimony regarding PAT. She described the available services, including regular personal visits (usually at home), group parent support meetings, screenings, and information and referral services. Additionally, Ms. Cernosek advocated for additional PAT funding to improve parenting skills, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness.

Susie Shanks, a recipient of PAT services, provided written testimony regarding her experience with the program and the benefits it provides, not just for families involved with CPS, but also for foster families. Ms. Shanks is an adoptive mother to three children with health challenges. Her children received critical screenings, and she received invaluable parenting support and information through the local PAT program. Ms. Shanks recommended that PAT be funded in every community.

5.13 LifeWorks Youth and Family Alliance
Anita Jung, Division Director for Counseling Services, provided testimony regarding the STAR program. STAR served more than 32,000 youth in 2007, but Ms. Jung pointed out that the real number of individuals that STAR touches is much greater, as family members are not counted. Ms. Jung highlighted the following positive outcomes of STAR during FY 2007:

- 84.1 percent of families report reduced family conflict;
- 82.4 percent of child runaways refrained from running away again;
- 80.3 percent of truant youth went back to school; and
- 94.5 percent of youth with a prior offense did not reoffend.

According to Ms. Jung, DFPS maintains high standards for the STAR program, monitoring providers rigorously. She encouraged greater support for the program

statewide and shared several personal success stories from her experience with STAR.

5.14 LifeWorks
On April 3, Susan McDowell, Executive Director, provided testimony regarding the impact of teen pregnancy on foster youth and initiatives aimed at preventing its occurrence or reoccurrence among this population.

Though teen pregnancy rates have declined by almost one third in the last decade, the United States still leads developed nations, and youth in foster care represent a population at particularly high risk:

- Approximately half of girls in foster care became pregnant at least once by age 19, and 71 percent experienced a pregnancy by age 21; and
- Teen pregnancy rates are more than two-and-one-half times those of non foster youth.

Teen parents are at greater risk for poverty, child abuse, and CPS involvement. Their overall educational and workforce attainment is lower, and they are more likely to become involved with the juvenile justice system. Their disproportionate representation among foster youth is troubling, as the children of these teenage mothers are more likely to enter the foster system and ultimately become teenage mothers themselves, thus perpetuating a cycle of abuse and neglect.

Ms. McDowell's recommendations for preventing teen pregnancy among the foster population centered around education, access to health care and contraception, and nurturing consistent and healthy adult relationships. Specifically, recommendations included:

- Increasing foster parent training on sexual health issues;
- Requiring age-appropriate sexual education for foster care youth at younger ages;
- Ensuring that foster youth have access to an adequate number of health providers and that they understand how to access preventive care;
- Providing long-term mentoring opportunities for youth aging out of care;
- Minimizing placements;
- Increasing the number of youth who remain in care after age 18; and
- Focusing resources on foster youth who are already pregnant to prevent their children from entering the system, as well as subsequent pregnancies.

5.15 Health Family Initiative
Amber Ramirez, Associate for Prevention Public Policy, provided written testimony on April 3 regarding the importance of home visitation programs, which have demonstrated cost effectiveness and sustained themselves at the local level in many cases. Home visitation programs have verified improved outcomes relating to school readiness, child health, parenting skills, family income, and abuse and neglect rates and are worthy of support. What's more, at $2,000-$5,000 per family per year, they are much less expensive than interventions through the foster care and juvenile justice systems.

Ms. Ramirez cautioned against implementing new pilots without a long-term, comprehensive statewide plan and sustained commitment. Additionally, she recommended that the state offer greater support to the "Raising Texas' Early Childhood Comprehensive Plan. Finally, she encouraged a balanced view of what is considered evidence-based programming so that families can be served throughout the state's many communities.

5.16 Darkness to Light

On April 3, Harold "Pat" Patrick, Chief Operating Officer, provided testimony regarding the Darkness to Light sexual abuse prevention program. Darkness to Light is a research-based program that emphasizes shifting responsibility of prevention from children to adults by moving adults from an awareness of sexual abuse into an advocacy role on behalf of children.

One in four girls and one in six boys are sexually abused before the age of 18, and half of these children are victims by age nine. It is estimated that there are 39 million survivors of sexual abuse in America today, and 90 percent were abused by someone they knew. The detrimental impacts of sexual abuse are numerous. Victims of sexual abuse are more likely to abuse substances, experience mental illness, attempt suicide, have eating disorders, and engage in risky sexual behavior than their non-abused peers. Consequently, there should be a greater focus on prevention of childhood sexual abuse.

Organizations like the Boy Scouts of America and the Catholic Church have paid out millions to settle cases related to sexual abuse, damaging their reputations and diminishing their ability to fulfill their mission. Darkness to Light focuses on training an organization's staff and volunteers in seven core proficiencies to protect children from sexual abuse. The program is currently utilized by 59 organizations in 38 Texas counties, including seven CACs. Mr. Patrick encouraged the state to consider implementing a statewide child sexual abuse prevention initiative.

5.17 Texans Care for Children

Susan Craven, Executive Director, provided testimony on April 3 in support of heavy investment in home-visitation programs across the state to prevent child abuse and neglect and promote healthy child development. According to Ms. Craven, these programs (e.g., PAT, NFP, and Healthy Families America) are a good investment because they influence children during the early years and reduce indirect expenditures in the long run. Texans Care for Children supports the development of home visitation services in every community in the state.

5.18 Family Connections

On April 3, Julie Crowe, Manager of Prevention and Early Intervention Services, provided testimony relating to Family Connections, an evidence-based home visitation prevention program developed by the University of Maryland School of Social Work and replicated by DePelchin in the Houston area.

The primary goal of Family Connections is to strengthen families in order to prevent incidents of child abuse and neglect. The program offers intensive services for a up to six months to families at high risk of abuse, neglect, and CPS involvement in an effort to:

- Assist with meeting basic needs (e.g. housing, utilities and food);
- Enhance well-being among children and parents/caregivers;
- Strengthen positive family interactions;
- Decrease caregiver risk factors; and
- Decrease child maltreatment in the targeted community.

Preliminary results from the DePelchin replication indicate the following clinically significant results:

- Decrease in problem behavior among children (at home and school as reported by parents and teachers;
- Decrease in feelings of stress among parents/caregivers;
- Decreased depression among parents/caregivers;
- Increase in positive parental social support; and
- Decrease in parental substance abuse.

The Family Connections model uses a master's level clinician to provide in-home individual and family therapy and individualized parent education, as well as bachelor's level trained case managers who link families to community resources and services, such as food banks, health care, and other basic services.

The cost to serve a family is between $2,000 and $3,000, compared to $20,000 per child in the foster system. The program can be readily replicated in most communities within the state and could be used as a prevention tool for targeting disproportionately represented children within the foster care system.

6. List of Acronyms

ACF	Administration for Children and Families
CAC	Children's Advocacy Center
CBCAP	Community-Based Child Abuse Prevention [program]
CBFS	Community-Based Family Services
CIS	Communities in Schools
CPS	Child Protective Services
CTF	Children's Trust Fund
CYD	Community Youth Development [program]
DFPS	Department of Family and Protective Services
FS	Family Strengthening [program]
FTDC	Family Treatment Drug Court
HHSC	Health and Human Services Commission
ICC	Interagency Coordinating Council for Building Healthy Families
NFP	Nurse Family Partnership
PAT	Parents as Teachers
PEI	Prevention and Early Intervention [division]
PRS	Department of Protective and Regulatory Services
SNYS	Statewide Network of Youth Services
STAR	Services to At-Risk Youth
TANF	Temporary Assistance for Needy Families
TEA	Texas Education Agency
TFTS	Texas Families: Together and Safe
YR	Youth Resiliency [program]

7. Notes

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CHARGE 4

Evaluate existing and past efforts by the state for youth transitions in independent living. Recommend improvements to educational, occupational, health, and life skills components of preparation of foster children for adult living.

1. Challenges for Transitioning Youth

The traumatic experiences of children who have been removed from their families understandably have a substantial impact into and throughout adulthood. For children aging out of foster care, negotiating the transition to adult life can present significant challenges, yet relatively few studies have attempted to quantify their success as adults.

The Northwest Foster Care Alumni Study provides insight into how foster youth fare after they leave the state's care. While this study did not focus specifically on Texas' foster alumni, its sample crosses several states and indicated the following trends among former foster youth:

- 54 percent have one or more mental health disorders;
- 25 percent experience post-traumatic stress disorder;
- 65 percent experience seven or more school changes;
- 21 percent complete any degree beyond high school;
- 2.7 percent complete a bachelor's degree;
- 22 percent are homeless at some point;
- 17 percent receive public cash assistance;
- 33 percent live in poverty; and
- 33 percent have no health insurance.[1]

2. Transition Supports

A youth in the child welfare system is said to "age out" of care when he or she reaches adulthood without having found a permanent home. Unfortunately, this is not an uncommon method of exit from Texas' foster care system— more than 1,400 youths left the system in this manner during FY 2007 (Table 4.1). In light of the health, educational, financial, and emotional challenges facing this population, state and federal governments, as well as non-profit organizations, have implemented programs to support current and former foster youth as they work to become healthy, productive adults.

Foster youth often require help with basic independent living skills, such as interpreting and signing a lease, balancing a check book, navigating the public transit system, budgeting, cooking, and doing laundry. For those who remain in a stable environment with one family, acquiring these skills may not present a challenge. For the majority of older foster youth, however, who often experience multiple placements and may spend at least some time in an institutional setting, there is little or no opportunity to learn and practice independent living skills. Many of these youth find themselves aging out of care without a high school diploma or driver license, both of which are essential in today's job market.

2.1 Preparation for Adult Living

Texas implemented the Preparation for Adult Living (PAL) program in 1986 to prepare older youth in care for their transition to independent living. Child Protective Services (CPS) policy provides an opportunity for every youth age 16 and older who is in paid substitute care, and for whom the Department of Family and Protective Services (DFPS) has permanent managing conservatorship (PMC), to participate in the PAL program. The majority of PAL services are funded through the federal Chafee Foster Care Independence Program, while 20 percent of funding is from state general revenue (GR) and community match.[2]

Table 4.1 Children No Longer in DFPS Legal Responsibility by Status

Status	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Aged Out of Care	*950*	*1,084*	*1,189*	*1,366*	*1,411*
Returned Home	3,899	3,913	4,098	5,518	5,908
Custody to Relatives	2,614	2,805	3,062	3,856	4,289
Adoption Consummation	2,444	2,512	3,173	3,376	4,023
Other*	503	603	653	726	623
TOTAL	**10,410**	**10,917**	**12,175**	**14,842**	**16,254**

Source: Texas Department of Family and Protective Services

Although PAL services are available in every region, all eligible youths are not served. In some cases, youth may refuse to participate. In other cases, PAL classes are not offered in a specific community, or a lack of transportation presents a barrier. Youth and caregivers in locations without access to PAL classes are offered a training manual to help caregivers teach independent living skills, but there is little oversight to ensure that the information is transmitted effectively.

The number and percentage of eligible youths between the ages of 16 and 20 who receive PAL services have increased in recent years (Table 4.2). It is important to note, however, that these numbers include youths who have received training manuals rather than participating in an actual class, as well as those who did not complete all PAL components.

Table 4.2 PAL Program Participation among Mandatory Population (Ages 16-20)

Fiscal Year	# Eligible	# Receiving Services	% Receiving Services
FY2007	8,356	7,639	91.0%
FY2006	7,884	7,279	92.3%
FY2005	7,262	6,474	89.1%
FY2004	6,383	5,341	83.7%
FY2003	5,849	4,921	84.1%
FY2002	5,272	4,297	81.5%

Source: Texas Department of Family and Protective Services

* Includes children who have run away, who are in court-ordered or independent living placements, children for whom conservatorship was never obtained (e.g., case dismissed at 14-day hearing), and children for whom data are missing.

2.1.1 PAL Classes

An initial assessment of each PAL participant is usually done around his or her 16th birthday to determine general readiness to live independently. The assessment is used to ascertain what instruction would be most helpful for that youth. PAL includes six general areas of study: personal and social relationships; financial management; housing and transportation; job readiness; health and safety; and life decisions/responsibilities. Because DFPS contracts with private providers for independent living skills training, the structure of classes looks different across the state. Some PAL classes are taught exclusively in a classroom setting, while other providers integrate traditional instruction with a more experiential, hands-on learning process.

2.1.2 Financial Assistance

After completion of the PAL program, youth are eligible for a transitional living allowance of up to $1,000, which is dispersed in increments of $200-500 per month. Youth may use the transitional living allowance at their discretion, but funds must be used before the age of 21. Additionally, recipients must be employed or enrolled in higher education and may not live with their abuse/neglect perpetrator as a condition of eligibility.

Aftercare room and board assistance is available to youth even if they do not complete PAL classes. This emergency funding can only be used to cover the cost of shelter and/or food and cannot exceed $3,000. Subject to funding availability, PAL may also subsidize expenses, including high-school graduation, prom, and driver education courses, for youth who are still in care.

2.1.3 PAL Activities

The PAL program offers the following activities to build character and healthy development:

- **PEAKS** is an annual two-day camp to improve self-esteem, communication, and problem-solving skills by engaging youth in activities (e.g., ropes courses, canoeing, expressive arts, swimming, nature hikes, skits, and journal writing). PEAKS camps accommodate 40 youths accompanied by an adult, preferably their caseworker;
- **Statewide Teen Conference** is held for three days each year on a college campus. Approximately 175 youths attend workshops related to preparing for adulthood, and DFPS gathers youth feedback to improve its programs;
- **College Weekend** takes place every spring on the Texas A&M Commerce campus. Approximately 70 youths planning to attend college participate in two days of workshops and receive individualized assistance and services related to attending college (e.g., filling out financial aid applications). Participants have an opportunity to meet former foster youth currently attending the university, as well as faculty and staff mentors and community sponsors; and
- **Statewide Youth Leadership Committee**, also known as the Youth Advisory Board, is made up of one youth from each region. The committee formulates

recommendations to improve services for children and youth in foster care. The group also reviews relevant policy as it is being developed.

Several regions have created additional activities and conferences to supplement their PAL programs. These may include wilderness trips, mentor programs, support groups, job development workshops, and youth forums.[3]

2.2 Circles of Support

In recent years, DFPS has dramatically increased its use of the Circles of Support transition planning model, implementing a standardized transition planning process for youth across the state beginning at the age of 16. Between September 2007 and April 2008, 1,149 youth participated in this type of transition planning, compared to only 571 during that same time period the year before.

The goal of a Circle of Support is to encourage family, friend, and community involvement in the life of a transitioning foster youth. The youth invites caring adults to participate in a meeting to identify short- and long-term goals related to education, employment, health, housing and life skills. Participants are asked to brainstorm and work collaboratively to outline a transition plan, and adult attendees make a personal commitment to help youth attain their goals.

2.3 Education Supports

Transitioning foster youth are eligible for a number of educational supports and services, including a tuition and fee waiver, the Education and Training Voucher (ETV) program, and partnerships with local colleges and universities.

2.3.1 Tuition and Fee Waiver

The tuition and fee waiver, enacted in 1993 and revised in 1997, exempts youth from payment of tuition and fees in any public college, university, or vocational program in the state. Texas' program is significantly more generous than tuition assistance programs in most other states. While 16 other states offer tuition and fee assistance to foster youth, only two offer full waivers.[4]

To be eligible for the tuition waiver, youth must have aged out of foster care or have been in care when they received a high school diploma or GED. Recently, program eligibility was expanded to youth who were adopted after their 14th birthday. Additionally, to access the waiver, youth must enroll in an institution of higher education no later than three years after receiving their high school diploma or GED, emancipation from care, or their 21st birthday, whichever comes first. Youth may use the waiver to acquire any level degree, from an associate's to a doctorate. In FY 2006, 1,563 former foster youth and 109 adopted youth benefitted from tuition and fee waivers.

2.3.2 Education and Training Voucher

ETV is a federally funded, state-administered program that provides assistance for youth between the ages of 16 and 23 who wish to pursue post-secondary education. Eligible youth may receive up to $5,000 per year to help offset the cost of attending school.

Vouchers can be used to help with transportation costs, supplies, books, living expenses, or even tuition at a private school. In FY 2007, more than 600 youth received funds through the ETV program, compared to 435 in FY 2006 and only 235 in FY 2005.

2.3.3 Collaborations

DFPS, in partnership with colleges and universities, has worked to create numerous supports for former foster youth who wish to attend college. Many colleges and universities have developed foster care alumni groups. Others, including Texas State University, the University of Texas at Pan American, the University of Texas at Arlington, Western Texas College, and Texas A&M University at Commerce, offer special scholarships to offset educational expenses. Texas A&M University at College Station employs a supportive staff person to assist university PAL students,[5] and Austin Community College appoints Campus Champions to serve as advisors for foster youth entering college.

2.4 Health Care

Since 2005, former foster youth have been eligible to receive transitional Medicaid coverage through the month of their 21st birthday without annual recertification. Youth may elect to remain in the STAR Health model, which provides a much richer array of services than traditional adult Medicaid. In 2007, legislation was passed to allow former foster youth enrolled in a higher education program and making satisfactory progress to continue Medicaid coverage until the age of 23, but funding was not appropriated for this provision.

2.5 Employment Supports

In 2006, DFPS entered into a memorandum of understanding with the Texas Workforce Commission (TWC) to serve current and former foster youth as priority populations.* Services vary based on available local resources, but services for youth may include child care, job skills development, access to computers, and job readiness programs. In some cases, these support services are delivered through the local transition center.

2.6 Extended Foster Care and Return to Care

Former foster youth who are pursing a high school diploma may elect to remain in foster care until the age of 22, and effective September 2006, youth pursuing vocational training may remain in care until the age of 21. The number of youth in extended foster care has increased every year since 2001 (Table 4.3).

Effective November 2007, youth ages 18-20 who previously aged out and chose not to remain in extended foster care have the option of returning to paid care in order to complete high school, a vocational training program, or return on break from an institution of higher learning for between one and four months. Youth who wish to return to care may do so by contacting their former caseworker, any DFPS employee, or Statewide Intake. As of April 2008, seven youths have chosen to exercise this option.

* Local workforce boards also signed individual agreements with DFPS regional offices.

2.7 Youth Input
In addition to explicit supports for transitioning foster youth, DFPS is a national leader in its efforts to solicit and incorporate feedback from former foster youth to improve supports for this population. Every year, DFPS conducts a survey of randomly selected youth in foster care to elicit opinions regarding available services. Additionally, DFPS conducts ongoing surveys of youth at discharge.

Table 4.3 Youth 18 and Older in Care

Month	Number of Youth 18 and Older
September 2007	479
September 2006	423
September 2005	335
September 2004	352
September 2003	315
September 2002	296
September 2001	233

Source: Texas Department of Family and Protective Services

Texas is the only state in the nation that incorporates the contributions of former foster youth in an official, paid capacity to support transitioning youth and further system improvements. DFPS employs a youth specialist in every region to mentor current and former foster youth, support the development of regional youth leadership councils, and advise local staff and community organizations on behalf of foster youth in their regions. This position provides a unique, much-needed consumer perspective regarding the practical impacts of policies and procedures.

2.8 Transition Centers
Transition centers are community-based, private entities that provide a continuum of services to assist older youth and foster care alumni to bridge the gap to adulthood. Numerous supports, including housing assistance, job training, education services, and financial support, are delivered in a single location for increased accessibility. Every transition center offers services in these general areas, but each program is structured differently, subject to resource availability and the specific needs of young adults in each community. Currently, there are ten transition centers operating in seven regions across Texas, including Austin, San Antonio, Houston, Dallas, Corpus Christi, Kingsville, Kerrville, Central Texas,* El Paso, and Beaumont/Port Arthur. Regions 1 (Lubbock), 2 (Abilene), 4 (Tyler), and 9 (Midland) have no transition center.

Four transition centers† receive limited state funding through contracts with DFPS to provide PAL and aftercare services, while six receive no direct DFPS funding. Consequently, transition centers must combine diverse public, private, and non-profit funding streams.

DFPS currently collects data only on the four centers with which it contracts. In FY 2007, these four centers served almost 2,500 youths.

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* Serves Belton, Killeen, and Temple.
† Austin, San Antonio, Houston, and Dallas

2.8.1 Case Management Services

Every transition center offers some optional case management services. Centers without DFPS contracts generally hire case managers to assist with case planning, follow-up services, and coordination with PAL case managers. Because eligibility for PAL services ends at age 21, most transition centers that contract with DFPS also employ additional case managers to work with older youth, subject to funding availability. Generally, case managers conduct needs assessments, review transition plans, assist youth in developing goals and service plans, make referrals both within and outside the transition center, and follow up to ensure that youth remain on track.

2.8.2 Counseling

Transition centers also offer counseling services, which may be provided by case managers or by licensed professionals. Counselors address numerous issues, including substance abuse, relationships, and crisis management. Some transition centers employ on-site counselors, and others partner with community-based organizations and agencies to provide group and individual counseling. If necessary, case managers may refer youth outside the center for counseling services that are not available on the campus.

2.8.3 Employment Services

Most transition center sites have partnered with TWC's local workforce development board to provide employment services. Centers may also work with community partners, such as Goodwill Industries, to provide paid internships, work experience, job placement, training, and coaching. In some areas, the transition center site has developed its own unique work program. For example, Lifeworks in Austin owns and operates a Ben & Jerry's site and uses it to teach job skills. Additionally, transition centers offer access to computers, voicemail, and a mailing address as foster youth conduct job searches.

2.8.4 Education

Most transition centers contract with education specialists or local agencies to provide tutoring and GED preparation. Case managers also help youth apply for financial aid, tuition waivers, and the ETV program. Some transition centers help youth enroll in college and work with universities to resolve outstanding financial and credit issues. In some cases, local colleges provide on-site enrollment and financial aid services on a regularly scheduled basis. Colleges may also partner with transition centers to offer on-site remedial college classes and short-term certificate programs. In cases where youth are no longer eligible for PAL services, transition centers may cover educational expenses for short-term certification programs.

2.8.5 Housing

Access to housing is often an enormous challenge for youth who have aged out of care. Because they lack a credit or rental history, landlords generally require a co-signer or an exorbitant security deposit. Even when youth have jobs and can afford monthly rent, these additional fees make obtaining housing extremely difficult.

Transition centers offer assistance by helping youth access housing vouchers or find alternative arrangements in the community at boarding houses or with family. Some

transition centers partner with emergency shelters, college dormitories, transitional living programs, and subsidized or supportive housing programs. Others will cover the cost of a motel room as a temporary living option. It is important to note, however, that affordable housing remains a serious obstacle to success for many former foster youth, and most services provided through transition centers have lengthy waiting lists.

2.8.6 Transportation

Transition centers offer limited transportation assistance, depending on community needs and resources. These may include bus passes, limited car repair assistance, or car pooling to special events. Some centers assist youth with the cost of driver education expenses and obtaining a driver license, but funding for this service is limited.

2.8.7 Miscellaneous Services

Because every community is different, transition centers do not provide a rigid, predetermined set of services. Some centers partner with social service agencies like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Others offer limited preventive health care services and assistance with enrollment in public programs. Most address meeting the basic needs of youth by providing lunch, operating a small food pantry, or opening a clothes closet. Caseworkers may assist youth in obtaining basic paperwork, such as birth certificates, social security cards, state identification cards, or school records. In other words, transition centers use resources flexibly to overcoming the challenges facing each youth they encounter.

2.9 Federal Support

In 1999, U.S. Congress passed the Foster Care Independence Act, also known as the Chafee Act, which established the John H. Chafee Foster Care Independence Program. The Chafee Act allows for greater flexibility in the use of federal funds to support emancipated youth and requires the provision of some services to former foster youth until the age of 21. Through the Chafee Foster Care Independence Program, states can design or enhance programming in the areas of housing,* life skills training, education, health,† and other needed supports. In 2001, the Promoting Safe and Stable Families Act amendments expanded the Chafee Foster Care Independence Program by providing federal funding for the ETV program. Texas has taken advantage of Chafee funding to enhance transition supports, including transitional Medicaid expansion and implementation of the ETV program.

In September 2008, the Fostering Connections to Success and Increasing Adoption Act was passed by the U.S. Congress and is currently awaiting the President's signature. This bill authorizes the use of federal funds for the first time for extended foster care programs until the age of 21. Because Texas currently allows former foster youth to remain in care, this new federal provision will result in cost savings for the state of approximately $1.5 million GR.

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* Up to 30 percent of Chafee funds may be used to provide room and board for former foster youth between the ages of 18 and 21.

† Texas uses Chafee funds for its transitional Medicaid program.

3. Remaining Challenges

Only a decade ago, there were no transition centers, the ETV program did not exist to help foster youth cover education-related costs, and aftercare case management was a new concept. Very few community colleges and universities understood the needs of foster youth, and youth interested in pursuing higher education were generally directed to one of a handful of universities familiar with foster youth and their distinct needs. Through a systematic approach to discharge planning, the use of federal and state funding to expand support services, and integration of the youth perspective, Texas has improved its transition services substantially.

Despite these significant improvements, several challenges remain. Addressing the remaining barriers to successful transition will enable the state to serve youth more effectively and, most importantly, improve long-term outcomes for foster youth. During the 80th Interim Session, the following challenges were identified:

- Large caseloads among PAL staff present a barrier to successful mentorship, advocacy, and service coordination;
- Limited resources preclude services to younger youth;
- PAL training often lacks a hands-on component;
- Youth access to the judicial process is limited;
- Teenage pregnancy, a phenomenon that is more common among foster youth, prevents successful transition and increases the likelihood of intergenerational involvement in the child welfare system;
- And many youth age out of the care without having acquired several basic and essential tools for success.

3.1 PAL Caseloads

Currently, the PAL program consists of 27 coordinators, two administrative technicians, and one supervisor to serve all transitioning foster youth in Texas. The average caseload for a PAL coordinator is 245 youths. In addition to providing individual case management for youth ages 16-21, PAL staff have numerous responsibilities, including administrative duties, training, transition planning (Circles of Support), aftercare monitoring, budget review, program reporting, contract monitoring, outreach, and conference coordination.

In some cases, PAL coordinators must cover vast regions of the state. Texas' 254 counties are distributed among 11 health and human services regions, and some geographic areas are much larger than others (Table 4.4). Consequently, a region's physical size can present a significant barrier to serving eligible youth. For example, PAL coordinators assigned to Regions 2 and 9 may have smaller caseloads, but one PAL coordinator is charged with covering 30 counties.

Table 4.4 PAL Caseloads by Region

Region	# of Counties Served	Youth in Care Ages 14-17*	PAL Staff
1 (Lubbock)	41	359	2
2 (Abilene)	30	166	1
3 (Arlington)	19	904	4
4 (Tyler)	22	275	1
5 (Beaumont)	15	155	1
6 (Houston)	13	901	7
7 (Austin)	30	591	4
8 (San Antonio)	29	700	5
9 (Midland)	30	145	1
10 (El Paso)	6	102	1
11 (Edinburg)	19	364	2

Source: Texas Department of Family and Protective Services

3.2 Limited Resources for Younger Youth

PAL policy requires that youth 16 and older in state conservatorship receive services, but regions may also serve youth beginning at age 14 if adequate funding is available. This is very rarely the case, yet the potential advantages of beginning PAL services at age 14 are numerous. Some youth may require more exposure to independent living skills training than can be provided in two years, and extended involvement with PAL allows youth to build on lessons over time. Additionally, older youth often experience multiple placements, and PAL classes are not available in every community in the state. Allowing youth in foster care to begin PAL services earlier creates a greater window of opportunity for them to benefit from the PAL program.

3.3 PAL Lacks Hands-On Component

Former foster youth often criticize the PAL life skills component for being provided in a classroom setting and offering few opportunities for practical application of the skills that they are expected to acquire. To be truly effective, youth should be engaged physically and mentally and encouraged to develop and use practical problem-solving skills. For example, rather than reading about the public transportation system, youth may be better served by researching routes, purchasing an actual ticket, and riding the bus with their instructor. Some life skills instructors effectively incorporate these kinds of activities, leading field trips to the grocery store and returning to prepare a balanced meal, allowing students to practice filling out actual lease agreements and job applications, and visiting the laundromat. Others may fail to incorporate these activities into their life skills training classes.

DFPS recently modified the contract for PAL life skills training to place greater emphasis on experiential activities and exposure to real-life activities and opportunities. Actual application of these requirements, however, may vary greatly. What's more, youth who live in areas without access to PAL classes may not receive these same experiential opportunities. This can be particularly problematic for foster youth with disabilities who

* At beginning of FY 2008

have difficulty learning in a traditional classroom setting or via correspondence course. In FY 2007, 1,616 foster youth received at least one component of the life skills training program, and 214 received only an Independent Living Workbook.

3.4 Youth Access to the Judicial Process

When a child's birth family fails to complete the court-ordered reunification plan within the required time limits, the judge grants permanent managing conservatorship (PMC) to DFPS. In some cases, the judge terminates parental rights, and the child becomes eligible for adoption. In other cases, parental rights are not terminated, and children are placed in long-term substitute care. Youth in PMC often spend many years in the child welfare system, either because they are ineligible for adoption (almost 5,000 children in FY 2007), or because they are waiting for an adoptive home (more than 9,000 children in FY 2007).[6]

A judge is required to review PMC cases at regular placement hearings,* yet youth often have limited ability to influence the decisions that are made. Scarce county resources force most judges to move attorneys and guardians ad litem to cases where DFPS has temporary managing conservatorship (TMC), and many Court Appointed State Advocate (CASA) programs lack the volunteers and resources to serve these youth as well. Conservatorship caseworkers have large caseloads, and turnover rates are high. What's more, statute allows judges to make the final decision regarding whether youth may attend their own placement hearings.† In other words, youth may be excluded from their hearing, lack representation by an attorney or guardian ad litem, and be represented only by a caseworker with whom they have spent very little time.

Numerous issues that have a direct impact on the life of a child are addressed at these hearings, including placement, permanency plans, visitation with parents and/or siblings, education, and health care. Often, youth have little or no opportunity to participate actively in the decisions that are made. Many former foster youth express frustration at the decisions that were made without their knowledge and feel that they should be included in the decision-making process.[7]

Once a youth reaches the age of 18, even in cases where he or she chooses to remain in extended foster care, the court is not required to continue judicial oversight. Youth, however, remain eligible for numerous services from DFPS after their 18th birthday, and many face challenges in accessing and coordinating these services. According to a report by the Texas Supreme Court's Permanent Judicial Commission on Children, Youth, and Families, statute is not clear regarding whether a court may opt to assert jurisdiction after the age of 18, even when DFPS remains involved in a youth's life.

The American Bar Association (ABA) recommends that former foster youth continue to have access to family courts until the age of 21 to ensure that they receive services for which they are eligible and to ease the transition into adulthood.[8] Many stakeholders feel that extended oversight could play a role in improving outcomes for former foster youth

* Placement hearings for children and youth in PMC are held every six months.
† Texas Family Code §263.503

by preventing homelessness, incarceration, and unemployment, as well as encouraging post-secondary education. Twenty-three states and the District of Columbia have followed the ABA's recommendation and statutorily require continued judicial oversight after the age of 18 (examples provided in Table 4.5).

Youth with disabilities often face numerous challenges in making the transition from foster care to independent living,[9] and extended judicial oversight could play a particularly important role in helping them navigate the system. In cases where youth have severe disabilities, the court could also ensure a smoother transition from services offered by DFPS to support systems available through the Department of Aging and Disability Services (DADS). Current statute allows for extended court jurisdiction in child support cases involving children who are not capable of self-support due to mental or physical disabilities.* The idea of expanding this oversight role to former foster youth with disabilities has a similar rationale.

Table 4.5 Selected States with Continued Judicial Oversight

State	Age Limit	Applicability
California	21	Reasonably foreseeable future harm or best interest (case law)
Colorado	21	All, unless terminated by court order
Illinois	21	Health, safety, and best interest of child require continuation of state guardianship
Kansas	21	Youth under 21 must request cessation of court's jurisdiction
Minnesota	19	Best interest; any interested party may request termination of jurisdiction
New York	21	Youth consent
Ohio	21	Youth with disabilities
Oregon	21	Mandatory until youth demonstrates stability and involvement in appropriate services
Pennsylvania	21	Youth consent and youth engaged in course of instruction or treatment

Source: Texas Supreme Court's Permanent Judicial Commission on Children, Youth, and Families

3.5 Teen Pregnancy Trends among Foster Youth

Texas has the highest teen birth rate among all states, and almost 20,000 teenage girls under the age of 18 gave birth in 2002.[10] Even more alarming, 24 percent of Texas' teen births in 2004 were the result of a repeat pregnancy.[11] Outcomes for teen mothers and their children are not encouraging. Teen mothers are less likely to finish high school and more likely to be unemployed than their peers. What's more, their children are more likely to perform poorly in school, suffer higher rates of abuse and neglect, and are more likely to enter foster care.[12]

Teenage pregnancy and birth rates are high in Texas, but the statistics for teenagers exiting the foster care system are cause for even greater concern. It is estimated that a third of teenage girls in foster care will experience at least one birth by the age of 19, a rate almost three times that of their peers.[13] More than 3,000 females exited Texas' foster care system between 2002 and 2007; if more than one third of them experience a pregnancy by age 19, that amounts to more than 1,000 children born to teenage foster

* Texas Family Code §154.302

youth and former foster youth over a six-year period. Among youth currently in care, DFPS reported that, at the beginning of FY 2008, 128 were already teen parents (Table 4.6).

Teen parents require a great deal of support to care for a child and meet his or her developmental needs, and this assistance is generally provided by the family. Current and former foster youth often lack that support, however, and many have understandably never learned appropriate parenting skills. When this support is lacking, it becomes even more likely that a child born to a teenage mother will enter the foster system, perpetuating a vicious cycle.

Table 4.6 Teen Parents in DFPS Custody

Region	Number of Teen Parents	Number of Youth Ages 14-17
Lubbock (1)	12	359
Abilene (2)	5	166
Arlington (3)	24	904
Tyler (4)	2	275
Beaumont (5)	3	155
Houston (6)	26	901
Austin (7)	16	591
San Antonio (8)	17	700
Midland (9)	3	145
El Paso (10)	2	102
Edinburg (11)	18	364
TOTAL	***128***	***4,662***

Source: Texas Department of Family and Protective Services

3.6 Youth Lack Basic Tools for Success

When a young adult enters the job market, it is certainly beneficial for him or her to have a high school diploma or equivalent and even better to have completed a secondary education program. Even absent those conditions, however, it is possible to find employment.

In contrast, there are a few essential items without which it is virtually impossible to find gainful employment, register for classes, apply for financial aid, open a bank account, apply for public housing, or fulfill any of the essential obligations to begin an independent life. During the 80th Interim Session, several foster alumni and advocates indicated that it is not uncommon for youth to age out of care without having been provided a birth certificate, picture identification, or social security cards. Lacking these basic documents is clearly a stumbling block to success.

What's more, an undeterminable but substantial portion of foster youth age out of care without a driver license. Even in cases where a youth cannot afford a car payment or liability insurance, having a license is a prerequisite for any number of jobs, and ensuring that youth have this basic skill, particularly in a state like Texas that lacks a robust public transportation system, will improve the likelihood that they will transition successfully.

4. Conclusion and Recommendations

Despite recent, significant improvements at both the state and federal levels to improve services and supports for transitioning foster youth, sustained commitment to further improvements is required. Based on testimony and comment provided during the 80th Interim Session, the House Committee on Human Services makes the following recommendations:

1. **Courts should be given clear statutory authority to extend jurisdiction in CPS cases to ensure that adequate services are provided via regular placement hearings and that youth have access to representation from attorneys and guardians ad litem.**

    a. Specifically, courts should have the option to continue judicial oversight for former foster youth when youth elect to remain in extended foster care and in cases where a youth has a significant physical, cognitive, developmental, or mental disability; and

    b. The court should be permitted to continue this jurisdiction until the youth's 21st birthday or until the youth withdraws his or her consent in writing.

2. **Direct GR savings resulting from increased federal assistance for extended foster care towards the PAL program to provide independent living skills training to more foster youth beginning at the age of 14.**

3. **Reduce caseloads for PAL coordinators.***

4. **Require assurance that hands-on, experiential activities are being provided in all PAL life-skills training programs.**

5. **Modify Texas Family Code §263.503 to make explicit that foster youth in PMC have the right to attend their regular placement hearings if they so choose.**

6. **Create a sustained state funding stream through DFPS to support transition centers in an effort to help them cover costs associated with overhead and staffing and to encourage the development of transition center models in the four regions where they do not currently exist.**

7. **Require that every foster youth be provided with an original birth certificate, social security card, and state identification card before they age out of care.**

8. **Require DFPS to work with the Department of Public Safety (DPS) to develop a plan to ensure that every foster youth has the opportunity to take a**

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* DFPS has requested $7.7 million GR as an exceptional item to improve services to transitioning youth in 2010-2011. A portion of these funds would allow the agency to hire 19 additional PAL caseworkers, reducing caseloads from 256 to 150.

driver education course and has access to affordable liability insurance.

9. **To reduce the fiscal and social impacts of teen pregnancy among foster youth:**

    a. Ensure that foster parents receive comprehensive training on sexual health issues;

    b. Expand the role of PAL in providing sexual health education for foster youth before the age of 16;

    c. Provide information to foster youth and former foster youth regarding how to access the sexual health services that they are currently eligible to receive; and

    d. Ensure access to comprehensive parenting education and support for transitioning teen parents.

10. **Support Texas CASA's efforts to recruit a volunteer for every child to enable CASAs to serve more youth in PMC and encourage children and youth in foster care to develop a bond with an adult mentor before they age out of care.**

5. Public Testimony and Comment

The House Committee on Human Services heard testimony on its fourth charge at two separate hearings (February 21, 2008, at the University of Texas at Arlington and April 3, 2008, at the Texas State Capitol in Austin). Testimony was provided by DFPS, stakeholder groups and the public at large. The following section summarizes testimony and comment received by the committee relating to transitioning youth.

5.1 Department of Family and Protective Services

On February 21, Joyce James, Assistant Commissioner of CPS, provided testimony regarding the PAL program. Created in 1986, PAL provides services to youth ages 16-20 who are currently transitioning out of care or who were formerly in foster care. Statewide, of the 8,356 youth who were eligible for PAL services in FY 2007, 91 percent participated. Ms. James explained that PAL services may be refused and that availability of some services varies across the state, which explains why the participation rate does not reach 100 percent.

Ms. James also described the following accomplishments specific to Region 3, which achieved a 98 percent PAL participation rate in FY 2007:

- Youth conferences are hosted in Region 3 by PAL staff and the Regional Youth Specialist;
- A Dallas County PAL unit focuses on children age 15 and older;
- TRAC Transition Center in Dallas County, one of eight transition centers in Texas at the time;
- Mentoring pilot program as directed by HB 3008 (80R) will begin in summer 2008 in Dallas, Tarrant, Collin, and Denton counties; and
- Held 227 Circles of Support with transitioning youth in FY 2007.

On April 3, Trista Miller, Region 7 Youth Specialist, provided testimony on her personal experience as an alumni of the foster care system. Ms. Miller described the following challenges in serving transitioning youth:

- Youth are not able to begin learning and practicing independent living skills early enough;
- Large PAL caseloads are not conducive to effective case management;
- Foster parents are not trained adequately to teach independent living skills;
- Some foster parents indicate that policies prevent them from effectively teaching independent living skills;
- Youth input should be emphasized even more;
- State and contracted agencies do not always communicate well;
- There are not enough housing options for transitioning youth.

5.2 Change for Today and Tomorrow

Change for Today and Tomorrow ($C4T^2$) is a branch of the Youth Leadership Committee, providing youth and alumni perspective for the practices, procedures, and policies of CPS that affect current and former foster youth. On February 21, members of

C4T² provided testimony regarding their personal experiences with the CPS system.

Members expressed appreciation and respect for the difficult work of caseworkers and recommended that they be compensated more fairly. Other testimony addressed the inadequacy of existing services to assist transitioning youth, particularly in the areas of money management and driver education. The group articulated a strong desire for equal treatment in relation to their peers outside the child welfare system and expressed concern that they would age out without the necessary skills to survive. One foster youth in particular felt discouraged about his chances of attending college. He explained that his school records were inadequate due to constant relocation, causing him to be set back two grade levels.

5.3 Transition Resource Action Center (TRAC)
Evy Kay Ritzen, Program Director for the Dallas County transition center, provided testimony on February 21 regarding the challenges faced by transitioning youth and the services transition centers provide. TRAC serves approximately 300 adolescents each year, many of whom experience between eight and nine placements within a period of five years. Ms. Ritzen expressed concern regarding access to mental health services, lack of job experience and readiness, and inadequate financial literacy. Ms. Ritzen recommended that transition centers receive direct funding from the state.

Ms. Ritzen's recommendations to the committee included:

- Changing state licensing rules to allow a continuum of housing options for transitioning youth, including independent living while still in state care;
- Encouraging Job Corps as a final placement for teens in care;
- Requiring teens in care to connect to workforce programs for in-school youth;
- Requiring a minimum standard of financial literacy for emancipated youth to receive transitional living allowances;
- Increasing funding for life skills training, transitional living allowances, and case management;
- Allocating case management funds to serve youth through age 25;
- Using PAL funds as incentives for participation in the program;
- Ensuring that children are properly prepared for the future educational or vocational track they choose;
- Preparing foster parents of teens and hold them accountable for preparing youth for independent living;
- Broadening mentoring programs for foster youth beyond the Texas Foster Grandparents Program; and
- Improving transitional Medicaid coverage, particularly to provide for mental health and medication needs.*

* Young adults transitioning from foster care who elect to remain in STAR Health receive all medically necessary community-based, rehabilitative, and inpatient behavioral health services, including substance abuse treatment. Young adults who opt out of the STAR Health model receive traditional Medicaid, which has more limited benefits.

5.4 Texas CASA

On February 21, several local CASA volunteers provided testimony regarding the lack of a safety net for foster youth aging out of care. Despite the existence of the extended care program, many foster youth leave care and drop out of school. Many of these have trouble finding employment, as they lack a driver license and access to reliable transportation. Volunteers emphasized the importance of developing bonds with adult mentors, many times a CASA, before aging out of care.

5.5 Center for Public Policy Priorities

F. Scott McCown, Executive Director, provided testimony on February 21 regarding transportation for foster youth. He recommended exploring strategies to ensure that youth aging out of care have driver licenses and access to affordable liability insurance through collaboration with DPS.

5.6 Permanent Judicial Commission for Children, Youth, and Families

On February 21, Tina Amberboy, Executive Director, discussed the need for better advocacy for every child aging out of care. This is currently not the case for children in PMC, who often have no access to an attorney or CASA due to limited resources.

Judge John Specia, Vice Chair, emphasized that transition centers are an effective way to serve transitioning foster youth. However, the state currently relies on a limited number of transition centers that cannot possibly cover all 254 counties.

5.7 Houston Alumni and Youth Center (H.A.Y. Center)

Pamela Walker, PAL Director, and Gracie Gonzalez, center client provided testimony to the committee regarding the H.A.Y. Center's services for transitioning youth. Ms. Gonzalez spoke of her positive personal experiences with the center as a transitioning youth.

Ms. Walker expressed concern that transitional Medicaid may not adequately cover substance abuse services because youth are allowed to opt out of the STAR Health package. She recommended that funding be provided for the expansion of transitional Medicaid to youth in post-secondary education until the age of 23, as well as for more comprehensive employment services. Additionally, Ms. Walker suggested that the state explore ways to fund services for youth over the age of 21. Finally, she recommended that transitional centers receive state funding to provide services and expand through satellite offices.

5.8 Casey Family Programs

Carolyne Rodriguez, Senior Director for Strategic Consulting, provided testimony on April 3, praising the accomplishments of DFPS in improving services for transitioning youth. Ms. Rodriguez highlighted the need for continued support and expansion of transition centers, as well as interagency collaboration to address the needs of youth living in rural areas and youth transitioning from the juvenile justice system. Ms. Rodriguez expressed support for the youth-driven Circle of Support model of transition planning, as it allows foster youth to begin to formalize their plans for the future,

promotes interpersonal relationships, and re-engages kin as potential permanency options. Ms. Rodriguez concluded by discussing the need to begin PAL classes earlier.

5.9 Advocacy, Incorporated

Richard Lavallo, Senior Attorney, provided testimony on April 3 regarding the experiences of a client with disabilities who had been in the care of CPS. Mr. Lavallo's client, Jessica Moore, also testified before the committee. Ms. Moore was placed in a residential treatment center (RTC) after her adoptive placement was disrupted, and her permanency goal became long-term institutional care. Mr. Lavallo and Ms. Moore indicated that hands-on, direct skills training rather than classroom learning is more effective for consumers with disabilities. Mr. Lavallo assisted Ms. Moore in finding a supportive housing program, where she has made drastic improvements through receipt of room and board, 24-hour supervision, and intensive case management.

Mr. Lavallo made the following recommendations to the committee:

- Use proven models from the Department of Assistive and Rehabilitative Services (DARS) and DADS to transition foster youth with mental health needs;
- Require continued representation from lawyers and CASA volunteers for as long as youth are eligible to receive services through the foster care system and in accordance with the Independent Living Initiative;
- Require every foster child to have a birth certificate, social security card, and identification card before he or she leaves care;
- Require collaboration and better sharing of funds among DFPS, DADS, and DARS to help youth with disabilities make successful transitions; and
- Improve case management to link youth to services and effectively deal with crises that arise when youth age out of care.

5.10 Lifeworks

Susan McDowell, Executive Director, provided testimony on April 3 regarding strategies to prevent teen pregnancy among foster youth. Lifeworks operates a mother and child program for pregnant and parenting teens, which currently houses six teenagers with children in Austin. Two of the six teens served are former foster youth, and one is pregnant with her third child.

Ms. McDowell's recommendations for preventing teen pregnancy among the foster population centered around education, access to health care and contraception, and nurturing consistent and healthy adult relationships. Specifically, recommendations included:

- Increasing foster parent training on sexual health issues;
- Requiring age-appropriate sexual education for foster care youth at younger ages;
- Ensuring that foster youth have access to an adequate number of health providers and that they understand how to access preventive care;
- Providing long-term mentoring opportunities for youth aging out of care;
- Minimizing placements;

- Increasing the number of youth who remain in care after age 18; and
- Focusing resources on foster youth who are already pregnant to prevent their children from entering the system, as well as subsequent pregnancies.

5.11 Judge Karin Bonicoro

Judge Karin Bonicoro is an associate judge appointed to preside over the Child Protection Court of Central Texas, one of 15 cluster courts across the state that serve rural areas and multi-county jurisdictions. Her current caseload consists of approximately 400 children, 250 of whom are in PMC.

Judge Bonicoro indicated little success in the counties over which she presides in helping transitioning youth, yet she applauded the efforts of a work group currently in place to address this population's concerns. Additionally, Central Texas CASA has applied for a grant through Children Justice Advocates to seek funding to implement a mentoring program, which would help the youth served by her court. Judge Bonicoro expressed her desire for youth in her region to access vocational opportunities, improve graduation rates, garner apprenticeship opportunities, obtain part-time employment while in school, and acquire driver licenses, even in cases where they don't have access to a vehicle.

5.12 Judge Darlene Byrne

On April 3, Judge Darlene Byrne, presiding judge for Travis County's 126th Judicial District Civil Court, provided testimony regarding the extension of judicial oversight to youth who have aged out of care. Judge Byrne underscored that existing statute on this issue is unclear and recommended that youth who have aged out of care, particularly those with disabilities or who haven't completed their high school diploma, be given access to regular judicial hearings. Without this oversight, youth have nowhere to go when they are unable to access services and supports for which they are eligible.

5.13 STARRY, Inc.

Rhonda Dyer, Executive Director, provided testimony on April 3 regarding the services provided by her organization. She offered support for the Shared Youth Vision Model and systems of care as comprehensive, effective ways to serve transitioning youth.

5.14 Other Public Testimony

Reverend Iman Edwards provided testimony on April 3 regarding obstacles for foster parents who try to teach independent living skills. Rev. Edwards indicated that licensing requirements present barriers to learning and practicing independent living skills. For example, if laundry detergent must be locked away at all times, it is difficult to teach youth to do their own laundry.

On April 3, Floyshae Smith, a former foster youth, described her personal experiences in the foster care system. She indicated that CPS did a good job of protecting her and her siblings and expressed support for the PAL program and transitional living allowance. Ms. Smith has had 11 caseworkers and more than a dozen placements. She recommended that more families take older children into their homes and that supportive living centers be expanded. Ms. Smith concluded by sharing her accomplishments and

future goals.

6. List of Acronyms

ABA	American Bar Association
CASA	Court Appointed Special Advocate
C4T^2	Change for Today and Tomorrow
CPS	Child Protective Services
DADS	Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
DFPS	Department of Family and Protective Services
DPS	Department of Public Safety
ETV	Education and Training Voucher
GR	General Revenue
H.A.Y.	Houston Alumni and Youth [center]
PAL	Preparation for Adult Living [program]
PMC	Permanent Managing Conservatorship
RTC	Residential Treatment Center
TMC	Temporary Managing Conservatorship
TRAC	Transition Resource Action Center
TWC	Texas Workforce Commission
WIC	[Special Supplemental Nutrition Program for] Women, Infants and Children

7. Notes

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CHARGE 5

Investigate the need for and potential of respite care programs to delay or avoid institutional placements, thereby resulting in cost savings for the state.

1. Defining Long-Term Care

Long-term care refers to the array of health services provided to persons with chronic illness and/or physical, developmental, or cognitive disabilities, including those who have lost the ability to care for themselves due to age-related disabilities. One popular misconception is that most individuals with long-term care needs receive services in an institution, such as a nursing or intermediate care facility (ICF). In reality, services are more often provided at home and in outpatient settings rather than in institutions,[1] and there is a growing emphasis on individuals with long-term care needs remaining in their homes and communities whenever possible.

Many seniors and persons with disabilities prefer to remain at home. Home-based care allows married couples to live together as they age and preserve their combined Social Security income and assets. For persons with disabilities, home and community-based services promote integrated community living rather than segregated care in a congregate setting. What's more, there is substantial evidence that home and community-based services can be provided at a lower cost to the consumer, as well as to the state in cases were Medicaid and/or general revenue (GR) are funding a portion of an individual's long-term care costs.

2. Long-Term Care Costs

Long-term care services are costly, regardless of where they are delivered, how they are subsidized, and who provides them. They are also increasingly necessary as the state's population ages. The long-term care insurance market has grown significantly over the past two decades,[2] but federal and state governments continue to subsidize a substantial portion of formal long-term care costs, particularly for persons who reside in institutional settings. Informal care-giving is also common, and there are measurable financial, physical, and emotional costs associated with this method of long-term care provision as well.

In light of the struggles families face in caring for their loved ones at home and the measurable, direct fiscal impact of care in institutional settings, many states have opted to invest in programs to support family caregivers. Often, the initial motivation is financial. A successful caregiver support program has the potential to minimize the indirect costs of informal care-giving while simultaneously reducing outlays for formal long-term care services that are directly funded by the state and federal governments. In addition to economic considerations, promoting and supporting informal care-giving at home enhances individual choice and improves the quality of life for many families.

2.1 Informal Care: Indirect Costs

For those individuals with long-term care needs who remain in their homes, most rely heavily on family members, neighbors, and friends to help them with the tasks of daily living that they are unable to complete on their own. In fact, an estimated 65 percent of

Texans needing assistance with daily living rely exclusively on informal caregivers.[3] In most of these cases, the state does not contribute directly to the individual's long-term care needs, but there is still a cost associated with providing this care, which is borne almost entirely by the family.

2.1.1 Uncompensated Labor

Texas is home to approximately 2.7 million informal caregivers who provide 2.9 billion hours of care at an estimated value of $24 billion each year (or an average of almost $9,000 in unpaid services per caregiver).[4] The opportunity cost of this uncompensated labor should be recognized in any cost analysis of long-term care services.

2.1.2 Out-of-Pocket Costs

In addition to the value of unpaid care, informal caregivers often incur substantial out-of-pocket costs. On average, adult caregivers spend more than $5,500 annually on household goods and foods, transportation, medical services, clothing, home repair/maintenance, and other necessary items for their loved ones.[5]

2.1.3 Employer Costs

Informal caregivers must compensate for the additional time spent to provide care for a loved one, and it is common for them to do so by spending less time on the job. In fact, 37 percent of caregivers report having quit a job or cut back on work hours to care for a family member or friend.[6] This translates to lost wages for the employee caregiver and lost productivity for Texas' businesses. In 2006, a MetLife cost study estimated additional employee costs for an average full-time employed caregiver (compared to a non-caregiver) at $2,110 annually (Table 5.1).

TABLE 5.1: Estimated Cost to Employers of All FTE Caregivers

Replacing Employees	$413
Absenteeism	$320
Partial Absenteeism	$121
Workday Interruptions	$394
Eldercare Crisis	$238
Supervisor Time	$113
Unpaid Leave	$212
Full-Time to Part-Time	$299
Total	*$2,110*

Source: MetLife Caregiving Cost Study[7]

2.1.4 Impact on Physical and Emotional Health

In addition to these quantifiable indirect costs, the emotional and physical strain that is placed on informal caregivers exacts a toll. An estimated 60 percent of family caregivers between the ages of 19 and 64 have fair or poor health, one or more chronic conditions, or a disability (nearly twice the rate of non-caregivers).[8] Furthermore, mortality risks are measurably greater for these caregivers when compared to their non-caregiving peers.[9]

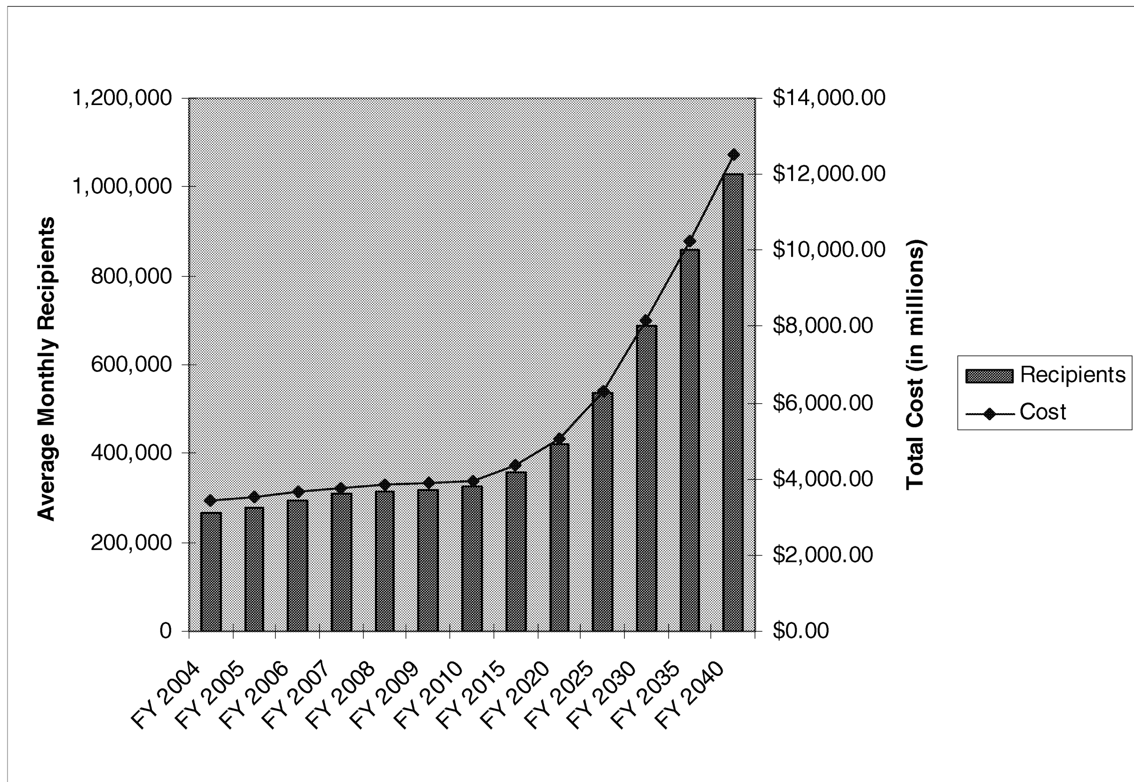
2.2 Formal Care: Direct Costs

Because individuals with long-term care needs who rely exclusively upon home-based care provided by family and friends are able to forgo or postpone formal services, the

aforementioned costs are not directly borne by the government. In cases where informal care-giving is impractical or unsustainable, persons with low to moderate incomes typically rely on Medicaid-funded long-term care services. Without informal caregivers, Medicaid expenditures would likely be much higher, giving the state a vested financial interest in ensuring that family caregivers are able to provide informal, home-based care for as long as possible.

There are many reasons to be concerned about the future of long-term care funding in Texas. Currently, Medicaid pays for 67 percent of all nursing facility care, and the number of Texans eligible for Medicaid long-term care services is projected to increase 370 percent by 2040. Much of this increase will be driven by population growth among individuals over the age of 85; between 2010 and 2040, this demographic is expected to increase 249 percent. Long-term care services and supports are particularly crucial among this age group, as 77 percent have a disabling condition.[10] Figure 5.1 illustrates projected growth in costs and in the number of recipients of nursing home, hospice, personal attendant, and other community care through 2040.

FIGURE 5.1. Medicaid Long-Term Care Projections



Source: Texas Health and Human Services Commission, System Forecasting

3. Benefits of Caregiver Support

In this context, delaying or preventing entry into Medicaid-funded long-term care services becomes both practical and necessary. Building upon and supporting the existing network of informal caregivers who wish to maintain their loved ones outside of

nursing facilities, ICFs, the foster care system, and other publically funded programs is an attractive option that may allow the state to capture low-hanging fruit. Because the availability of support services for informal caregivers certainly influences their willingness and ability to continue to provide home-based informal care, these services have the potential to reap the following benefits:

- Individuals with disabilities can exercise greater choice regarding where and from whom they receive care;
- Families will experience reduced emotional, physical, and financial stress;
- Couples, particularly those who rely primarily on Social Security, can keep a greater portion of their income in the home;
- Individuals and families may preserve a greater portion of their estate;
- Employers will experience increased productivity; and
- The state of Texas may be able to slow growth in long-term care expenditures.

4. Respite

The support service most frequently requested by informal caregivers is respite care.[11] Respite services, which provide temporary relief for caregivers, may be structured in a variety of ways and delivered in any number of settings over varying lengths of time. Generally, respite care may be provided either in or outside of a home setting:

- **Home-based services** may be provided by employees of home-health agencies, trained volunteers for non-profit organizations, or by an individual selected by the family or care recipient and trained by a respite program. The principal distinction between home health long-term care services and in-home respite is the temporary and/or periodic nature of respite care. In some cases, particularly for children with disabilities, respite may be provided in a licensed provider's home;
- **Day care services** may be targeted towards children with disabilities to provide parents with a break or towards adults who need companionship and/or assistance while their caregivers are at work or handling personal business. Churches, non-profit agencies, or local government entities often provide this type of respite care;
- **Facility-based respite** may be provided in assisted living or nursing facilities, ICFs, hospitals, or other congregate care settings. Advocates for the elderly and persons with disabilities typically prefer home-based and day care services to this more restrictive option; and
- **Hospice**, while providing benefits other than respite, plays a similar role by offering caregiver support so that individuals with terminal illness may remain at home or out of an acute care setting. Hospice is covered by both Medicare and Medicaid for qualified beneficiaries.

4.1 State-Funded Respite Services

Texas' Department of Aging and Disability Services (DADS) offers respite services in each of its Medicaid 1915(c) waivers, through its In-Home and Family Support Program

(IHFS), and through Older Americans Act (OAA) services, which are administered by Area Agencies on Aging (AAAs). Table 5.2 provides greater detail regarding the number of recipients and average cost of care in each program administered by DADS.

In addition to the programs described in Table 5.2, more than 17,000 Texans with incomes at or below the Supplemental Security Income (SSI) limit* benefit each month from Day Activity and Health Services (DAHS), a Medicaid entitlement service. While not strictly defined as respite, DAHS does provide temporary relief for informal caregivers. Recent rule changes at the Centers for Medicare and Medicaid Services (CMS) may reduce federal funding for DAHS dramatically. In response, DADS is working with CMS to apply for a 1915(i) waiver (as authorized by the federal Deficit Reduction Act (DRA) of 2005) to include DAHS services in the state Medicaid plan. If approved, Texas will be able to continue to draw down funds for this critical service.

TABLE 5.2 DADS Respite Services, FY 2007

Program	*Community -Based Alternatives (CBA)*	*Home and Community -Based Services (HCS)*	*Community Living Assistance and Support Services (CLASS)*	*Deaf-Blind Multiple Disabilities (DBMD)*	*Medically Dependent Children Program (MDCP)*	*Consolidated Waiver Program (CWP)*	*Texas Home Living Waiver (TxHML)*	*In-Home Family Support Services (IHFS)*	*Services provided through AAAs*
Population Served	Aged and disabled adults; alternative to care in a nursing facility	Persons with cognitive and intellectual disabilities; alternative to care in an ICF	Persons with a related disability; alternative to care in an ICF	Persons with deaf-blindness and one or more other disabilities; alternative to care in an ICF	Medically dependent children; alternative to care in a nursing facility	Bexar County individuals eligible for any of the 1915(c) waiver programs	Persons with cognitive and intellectual disabilities and related conditions; alternative to care in an ICF	Persons with physical disabilities *not* on Medicaid waiver programs	Persons 60+ and their caregivers
# Served	1,633	1,174	2,153	34	2,715	14	885	Unavailable	5,172
Avg. Annual Cost	$1,711	$1,013	$2,386	$3,580	$8,673	$3,479	$2,567	Unavailable	In-Home or Inst.: $711 Adult Day Care: $1,765

Source: Texas Department of Aging and Disability Services

4.2 Federal Respite Initiatives

The OAA Amendments of 2000 added the National Family Caregiver Support Program under Title III, which provides assistance and services to caregivers of the elderly. Services, including respite care, are provided through organizations like Aging and Disability Resource Centers (ADRCs) and AAAs and are targeted primarily to individuals age 60 and older.[12] It is important to understand that OAA funds benefit aging caregivers and caregivers of the aging, but they are not intended to serve non-

* Currently $603 per month

elderly caregivers of younger Texans with disabling conditions. In other words, a significant portion of the population that could potentially benefit from respite services cannot access OAA funds.

In 2006, Congress passed the Lifespan Respite Care Act to make respite more accessible and affordable to family caregivers. This legislation authorizes competitive grants to ADRCs and state respite coalitions to create programs and services that any caregiver may utilize, regardless of age or disability. To apply for the competitive grant, a state's governor would submit an application on behalf of the agency that administers OAA funds and/or Medicaid (or another agency as determined by the governor).[13] While $70 million was authorized for FY 2007 and FY 2008, these funds were never appropriated. The United States Senate reserved $53 million through a budget resolution to fund this act in FY 2009.[14] If these funds are appropriated in the budget process, states may then begin to apply for these federal respite dollars.

4.3 Other State Initiatives

Several states, including Oregon, Nebraska, and Wisconsin, have enacted lifespan respite legislation to expand and coordinate access to respite services for informal caregivers of persons with long-term care needs. Lifespan respite acts have been passed more recently in Arizona and Michigan. Each program is structured somewhat differently. In general, however, the appropriate health and human services agency in each state contracts with community-based organizations and/or state respite networks to create a regional single point of contact for coordinated access to respite services, without consideration of age or disability to determine eligibility. The state plays an oversight role, providing technical assistance, training, and other administrative services.

Other states have also undertaken initiatives relating to lifespan respite services. Oklahoma established the Oklahoma Respite Resource Network, which is a statewide, public-private partnership that aims to increase the availability of respite care. Through this network, families are entitled to a respite voucher and may consider family, friends, churches, co-workers, child care centers, or other public organizations as potential respite providers. In addition, a number of states have held state lifespan respite summits, including Alabama, New Jersey, North Carolina, Tennessee, Kansas, Illinois, and Pennsylvania.[15]

The Oklahoma program provides a useful example of how a public-private respite network might be structured. The respite network maintains a list of public and private agencies that provide respite services. Interested caregivers complete a respite application and, if eligible, receive a voucher that can be used to purchase respite services from their provider of choice. While the respite provider may be an agency listed in the network, the voucher may also be used to pay for the services of any person the caregiver chooses, so long as that person is at least 18 years of age and is not an immediate family member who lives in the home.

Any caregiver of a person over the age of 60 is eligible to receive respite vouchers, regardless of income. Respite vouchers of up to $1,200 per year are also available for

families with annual incomes below $60,000 who care for a person under 60 with a developmental disability. Eligible individuals include the following:

- Grandparents over the age of 60 who are raising a grandchild in the home;
- Grandparents under the age of 60 who are raising a grandchild with developmental disabilities in the home;
- Family members of any age who are caring for a person over the age of 60 with chronic health conditions, including Alzheimer's and dementia, and requires assistance with daily living;
- Families who have adopted a child with special needs;
- Families caring for a child with developmental disabilities who is not participating in another state-funded program that offers respite, such as a community-based waiver program; and
- Families with a child who is receiving SSI.[16]

5. Service Gaps

Existing respite programs for Texas' caregivers are a critical component of the state's continuum of long-term care services. However, eligibility requirements for these programs limit those who may benefit. Income eligibility criteria for most state-funded programs that offer respite care exclude individual earning more than 300 percent of the monthly income limit for SSI, or $1,911 per month.

5.1 Eligible Persons

Texas is home to more than 600,000 elderly adults and persons with disabilities at or below 300 percent of the income limit for SSI who require assistance with daily tasks. These individuals are potentially eligible for Medicaid services, but 65 percent receive care exclusively from an informal caregiver.[17] While these persons are eligible for respite through the IHFS program and, in some cases, AAAs and DAHS, DADS currently lacks the resources to serve those who request respite services, let alone the entire eligible population.

5.2 Persons with Moderate Incomes

In addition to the aforementioned population, there are ineligible persons who would benefit greatly from greater access to respite care. Even individuals and couples with significantly higher incomes than 300 percent of the SSI limit would spend down to Medicaid eligibility fairly quickly in the event that formal home care or nursing facility services were required. The average cost of nursing facility care in Texas is $2,900 per month,[18] which would consume the income of a person earning more than three times the Federal Poverty Level (FPL) or a couple earning two and one half times the FPL.

While AAA services lack income eligibility criteria, they are generally targeted to the neediest individuals, and they were only able to serve 3,224 caregivers statewide in 2007. IHFS is the single state program serving individuals at higher income levels, at almost any age, and without resource eligibility requirements. Funding for this program was $4 million in FY 2008, and only a portion goes to provide respite care. In 2007, fewer than

4,000 caregivers received respite care statewide, but more than 14,000 were on a waiting list for an IHFS service in January 2008.[19] In short, even though many of these individuals can afford to pay on a sliding scale for these services, access to respite care is extremely limited.

5.3. Persons with Disabilities

Finding respite for caregivers of persons with disabilities can be similarly challenging. Current programs are generally set up to support either the elderly or those with low incomes. For example, AAAs can only provide services to caregivers or care recipients over the age of 60,* which does nothing to support a 50-year-old caring for a spouse with traumatic brain injury or early-onset Alzheimer's, a 40-year-old caring for a sibling with cognitive disabilities, or a 59-year-old caring for a child with multiple sclerosis. If these families do not meet the stringent income requirements for Medicaid waiver services or home care services, their options are extremely limited.

5.4 Efforts to Address Respite Needs

In its 2007 *Effectiveness and Efficiency* report, the Legislative Budget Board (LBB) recognized this gap recommended that Texas follow in the footsteps of other states by appropriating $300,000 over the biennium to establish a lifespan respite pilot program. During the 2007 Legislative Session (80R), Representative John Davis (R-Harris) and Senator Judith Zaffirini (D-Laredo) filed bills to implement this recommendation. SB 1865 by Zaffirini directed DADS to implement a lifespan respite services pilot program to promote the provision of respite services, to develop state and local infrastructure for the provision of those services, and to evaluate the pilot's impact on Medicaid long-term care expenditures. SB 1865 was passed by the Senate, reported favorably by the House Committee on Human Services, and placed on the General State Calendar, but it was never considered by the full House.

6. Benefits of Respite Services

Several studies have found that access to respite services improves the health and well-being of families, reduces health care service utilization, and reduces the risk of out-of-home placements (Table 5.3). These findings are true for caregivers of children and adults with disabilities, as well as for the elderly. While respite services may not eliminate the need for more formal services later on, even a modest delay of entry into a Medicaid waiver program or nursing facility has the potential to reap substantial cost savings.

Some researchers have noted, however, that existing studies examining the effects of respite care on institutionalization rates suffer from methodological problems, rendering public policy conclusions challenging. The Health Technology Assessment program conducted a comprehensive, systematic review of published studies related to the impact of respite programs in 2007 and concluded that the evidence base neither supports nor refutes the hypothesis that residential care may be delayed through expansion of respite services. The authors recommend that pilot studies be conducted in the future to inform

* Grandparents over age 55 who are caring for a minor grandchild are the single exception.

public policy development more comprehensively.[20]

TABLE 5.3 Research Summary of Respite Benefits

Author/Organization	*Year*	*Population*	*Finding*
Cohen and Warren	1985	younger family members	Improved family functioning, satisfaction, stress-coping mechanisms, attitude towards family member.
Human Services Research Institute	1995	children with disabilities	Improvement in ability to provide care at home (74%); 35% would have considered out-of-home placements without respite.
Sherman	1995	children with chronic illnesses	Significant reduction in somatic complaints by caregiver and decrease in number of hospitalization days for children.
Cowen and Slavik	1996	children with developmental disabilities	Statistically significant decrease in foster care placement.
Bruns	1999	children with serious emotional disturbance	Fewer out-of-home placements and improved optimism about the future.
Chang, Karuza, Katz et al	1992	elderly with chronic disabilities	Fewer hospital admissions for acute medical care.
Theis	1994	elderly	Improved physical health (64%) and emotional health (78%) for caregiver; improved care for the recipient (50%); and less likely to resort to institutionalization (40%).
Zarit et al	1998	persons with dementia	Users of adult day care services experienced lower levels of stress and better psychological well-being in both the short and long term.
Oklahoma Respite Resource network	2004	lifespan respite program participants	Allowed loved one to remain at home (88%); improved quality of care (98%); and improved marriage stability (79.5%).
Jackson	2001	Nebraska respite recipients	Less likely to place children in out-of-home care; decreased stress (79%); and decreased isolation (58%).
Wade, Edgar, and Baker	2003	respite recipients	May reduce likelihood of divorce.

Source: National Respite Coalition[21]

7. Cost Estimates

Estimating the state's potential cost savings through increased access to respite services is difficult due to a lack of key baseline information. First, the level, duration, and frequency of the proposed respite intervention should be defined. Second, the target population must be identified. Third, the recipient caregiver contribution must be determined, if applicable. Fourth, the existing evidence base regarding the potential for respite care to delay or prevent institutionalization should be more robust. In addition to these challenges, a true cost analysis would consider benefits other than impact on GR, such as increased wages and productivity, improved health, and reduced stress, and these can be difficult to quantify.

Recognizing the challenges of producing a reasonable cost-savings estimate with currently available information, policy makers have proposed pilot programs to look specifically at the potential of respite care to delay or prevent institutionalization and decrease the state's long-term care outlays. Such an analysis is clearly beyond the scope of this report. However, generalizations may be made from available data regarding the cost of respite services currently provided by the state, as well as the cost of Medicaid-funded long-term care services.

7.1 Respite Services
The cost of providing respite care varies greatly based on the needs of the population served, the characteristics of the provider, and the intensity of the intervention. The average annual cost of respite care for current recipients ranges from approximately $700 for in-home and institutional respite services provided through AAAs to almost $9,000 in the Medically Dependent Children Program (MDCP). The average cost of respite services offered through waiver programs is approximately $4,000 per year.* These are typically higher than respite costs reported in non-waiver programs (e.g., AAA services) and therefore may overestimate the true cost of respite care.

7.2 Nursing Facilities
Nursing facility care is a large cost driver in Texas' Medicaid budget. In FY 2007, average daily census for Medicaid beds in nursing facilities was 56,689, for which facilities received reimbursements of $2.2 billion. Approximately one third ($688 million) was contribute by state GR, with patient applied income (SSI or Social Security) and federal Medicaid match making up the difference. In sum, the cost of nursing facility care for 57,000 Medicaid-eligible Texans totaled $2.3 billion in FY 2007, for an average annual cost of approximately $38,000. (Table 5.4).

TABLE 5.4 Average Daily Cost of Medicaid Bed by Source, FY 2007

	Patient	*State GR*	*Federal*	*Total*
Daily Rate	$21	$33	$51	$105
Annual Total	$462 million	$739 million	$1.1 billion	$2.3 billion
% Paid	19.7%	31.5%	48.8%	100%

Source: Texas Department of Aging and Disability Services

In addition to these Medicaid-funded beds, some Medicaid-eligible nursing home residents are funded each month, at least partially, by Medicare. These are clients who are eligible for both Medicare (based on age and/or disability) and Medicaid (based on income and disability). Medicare does not fund long-term nursing facility care, but it will reimburse 100 percent of the cost of rehabilitative skilled nursing care for up to 20 days and a portion for up to 100 days (e.g., after a hospitalization).[22]

In FY 2007, an additional 6,373 dual-eligible clients received some Medicare funding for their nursing facility stay every month.† Because Medicare is funded federally, DADS does not have access to data showing the amount contributed by Medicare for these individuals' care. For the Medicaid coinsurance portion, however, nursing facilities received a total of $155 million, of which GR contributed approximately one third ($51 million).

* Sum of all respite costs divided by the total number served across all DADS programs.
† These individuals are not included in the Medicaid average daily census count.

7.3 Cost Savings

Using the average annual cost of respite services in waiver programs and the average annual cost of nursing facility care,* it is possible to produce basic estimates of potential costs savings related to increased access to respite. The results of a rigorous pilot study evaluation would be needed to narrow the range of possibilities.

Table 5.5 presents projected savings per person under eight scenarios. In the first row, it is assumed that institutionalization is neither prevented nor delayed by a state expenditure of $4,078 to provide respite for 12 months to the caregiver of a Medicaid-eligible or potentially Medicaid-eligible person at risk of entry into a nursing facility. The final row contains estimated cost savings in the case that institutional care is delayed for six months on average.

TABLE 5.5 Estimated Cost Savings of Respite by Beneficiary: Eight Scenarios†

	Average Expenditures Per Person					**Average Savings Per Person‡**					
	Nursing Facility										
Average Delay	*Applied Income*	*State GR*	*Federal Match*	*Respite Care*	*Total*	*Personal*	*State*	*Federal*	*Total*	*Savings*	*Net Impact on GR*
No Effect	$7,680	$12,086	$18,722	$4,078	$42,566	$0	$0	$0	$0	-$4,078	-$4,078
2 weeks	$7,360	$11,583	$17,942	$4,078	$40,963	$320	$504	$780	$1,604	-$2,475	-$3,575
1 month	$7,040	$11,079	$17,162	$4,078	$39,359	$640	$1,007	$1,560	$3,207	-$871	-$3,071
2 months	$6,400	$10,072	$15,602	$4,078	$36,152	$1,280	$2,014	$3,120	$6,415	$2,336	-$2,064
3 months	$5,760	$9,065	$14,042	$4,078	$32,945	$1,920	$3,022	$4,681	$9,622	$5,543	-$1,056
4 months	$5,120	$8,057	$12,481	$4,078	$29,736	$2,560	$4,029	$6,241	$12,829	$8,752	-$49
5 months	$4,480	$7,050	$10,921	$4,078	$26,529	$3,200	$5,036	$7,801	$16,037	$11,959	$958
6 months	$3,840	$6,043	$9,361	$4,078	$23,322	$3,840	$6,043	$9,361	$19,244	$15,166	$1,965

Source: Based on data from the Texas Department of Aging and Disability Services

Under a middle scenario, in which entry into nursing facility care is delayed by three months on average, one year of respite care would reduce total outlays for nursing facility care by $9,622 per person. The individual (and his/her spouse if applicable) would preserve $1,920 of their Social Security income, the state would expend $3,022 less in nursing facility reimbursement, and the federal government would save $4,681 in Medicaid match. Taking into account the cost of the respite care itself, cost savings to all payors would total $5,543.

Clearly, continued research is necessary to estimate more precisely the effects of respite services on institutionalization and its potential to reduce Texas' long-term care outlays. A thorough analysis should include the precise cost of the intervention under consideration, as well as the potential impact of eligibility and cost-sharing requirements. Moreover, it is important to recognize that respite services also result in benefits without easily definable cost equivalents. For example, effects on family well-being and stability,

* Excludes outlays for dual-eligible clients, which are tabulated using a different methodology.

† All estimates are based on actual FY 2007 expenditures reported by DADS. Estimates exclude costs for dual-eligible clients.

‡ Compared to average yearly cost of a Medicaid-funded nursing facility bed ($38,488).

caregiver and care recipient health, and workplace productivity should be considered.

8. Conclusion and Recommendations

The ability of informal caregivers to support their loved ones is a factor influencing whether individuals with long-term care needs are able to remain in the community, but access to services that support their efforts is limited. Absent relief, many caregivers experience substantial physical, emotional, and financial pressures, which may ultimately compel them to place their loved one in an institution.

Testimony provided to the Human Services Committee during the 2008 Interim Session underscored the importance of respite services for individuals of all ages, from children with behavioral health needs and/or intellectual and physical disabilities to aging adults with Alzheimer's/dementia. Despite widespread need for these services and their potential to prevent placements in nursing facilities, intermediate care facilities, and state hospitals, as well as entry into the foster care system, many families remain ineligible for or unable to access respite care.

Taking into account input from DADS, providers, advocates, caregivers, and other stakeholders, as well as estimates indicating the potential for substantial cost savings through the provision of respite services, the House Committee on Human Services makes the following recommendations.

1. **The Legislature should establish and fund a lifespan respite pilot program to be administered by DADS in one region of the state.**

    a. Services should be made available to individuals, regardless of age or disability, but may incorporate income eligibility requirements more generous than those in Medicaid-funded programs;

    b. The program should be modeled after successful lifespan respite programs in other states like Oregon or Oklahoma;

    c. The Legislature should consider providing more than the biennial appropriation of $300,000 that was proposed during the 80th Legislative Session to ensure that participating families have access to a reasonable amount of respite; and

    d. DADS, in collaboration with the Health and Human Services Commission (HHSC), should submit a report to the 82nd Texas Legislature to:

        i. evaluate the program's success in delaying or preventing institutional placement;

        ii. assess potential cost savings, both in terms of GR and All Funds;

        iii. measure its impact on the stability and well-being of participating families; and

iv. make recommendations regarding eligibility requirements for an expanded, statewide model that maximizes personal and government resources by maintaining persons with disabilities in their homes.

2. **DADS and HHSC should explore strategies to draw down federal funding for respite care, including the availability of federal funding through the Lifespan Respite Act.**

3. **The Legislature should appropriate additional GR for the IHFS program to provide respite to caregivers of recipients who do not qualify for OAA funding or current Medicaid-funded respite services.**

4. **Legislation should be passed to support informal caregivers who may not meet income eligibility requirements for a lifespan respite program by allowing them to use paid and personal sick leave, if offered by their employer, to care for family members with a disabling condition. This legislation should:**

    a. Build on the provisions of the federal Family Medical Leave Act; and

    b. Work in concert with the existing leave policies of Texas employers.

9. Testimony and Public Comment

The House Committee on Human Services heard testimony on its fifth interim charge at two separate hearings. The first was held on March 13, 2008 at the University of Houston, Clear Lake, and the second meeting of the committee on this issue took place on May 1, 2008 at the State Capitol in Austin. Testimony was provided by DADS, stakeholder groups, and the public at large. The following section summarizes public and written testimony received by the committee relating to respite services.

9.1 Department of Aging and Disability Services

On March 13, Commissioner Adelaide Horn provided testimony describing respite services available specifically to the aging population. The state and federally funded programs offering respite include DADS Medicaid 1915(c) waivers, IHFS, and services provided through AAAs. The DAHS program, which is particularly important in the Rio Grande Valley, provides adult day care services.

More specifically, respite services in nursing facilities, assisted living facilities, and adult foster care homes are available to older individuals through the CBA waiver program. The CWP program offers respite care in foster homes, hospitals, and nursing facilities. Respite is also a key feature of the National Family Caregiver Support Program and is available through AAAs both in and out of the home through hospitals, nursing facilities, adult day centers, home and community support service agencies, and through a voucher program.

According to Commissioner Horn, fewer than 7,000 aging Texans received respite services in FY 2007 through DADS-administered programs. The annual cost of these services varied based on the program, from $711 for in-home and institutional respite services provided through AAAs to $3,479 for participants in CWP.

9.2 Advocacy, Incorporated

James Meadours and Jeff Miller of Advocacy, Incorporated provided testimony on March 13 regarding the importance of providing respite services for persons with disabilities in their family homes so that these individuals are not placed in a state school or other institution in a crisis situation. Mr. Meadours and Mr. Miller underscored that respite services should be provided in the community.

On May 1, Mr. Meadours provided additional testimony to encourage restoration of safety-net crisis funds for services provided through IHFS and Mental Retardation Authorities (MRAs). Mr. Meadours indicated that funding should be flexible and available to all caregivers, regardless of age or the disability of the care recipient.

9.3 National Multiple Sclerosis Society, Lone Star Chapter

Shannon Brooks represented the National Multiple Sclerosis (MS) Society's support for expansion of current respite services to individuals who are not currently eligible through implementation of a lifespan respite program. This would include caregivers of those who do not qualify for funding through the Older Americans Act or through Medicaid waivers and other DADS programs.

Ms. Brooks presented data on May 1 indicating that there are 393,000 older adults and non-aged persons with disabilities in Texas with incomes below 220 percent of the FPL, need help with daily living, and receive all long-term care services through the support of family and friends. She highlighted research suggesting that respite care is the most requested service among informal caregivers, reduces strain on caregivers, allows informal caregivers to remain in the workforce longer, prevents institutionalization of care recipients, and saves the state money.

Ms. Brooks concluded by asserting that the $300,000 appropriation recommended by the LBB in 2007 would only cover the program's administrative costs and not the cost of providing services. She recommended that the Legislature consider a larger appropriation for such a program in the future.

Linda Coker, a member of the Lone Star Chapter of the National MS Society, presented personal testimony regarding the emotional and financial strain she and her family have experienced as a result of her sister's illness.

9.4 Nacogdoches Treatment Center

Kathy Strong, Mary Anne Oglesby, and Stephen Crain provided testimony on May 1 regarding the importance of respite services in their community. The Nacogdoches Treatment Center is a non-profit corporation that serves individuals with Alzheimer's Disease/dementia through a four-hour day activity program. These services provide temporary respite to caregivers of individuals with Alzheimer's/dementia and delays entry into nursing facilities for many.

9.5 Texas Silver-Haired Legislature

Chris Kyker, Speaker, provided testimony on May 1 on behalf of the Texas Silver-Haired Legislature. Ms. Kyker advocated on behalf of expanding Texas' family caregiver initiative an effective means of delaying and/or avoiding institutional care and entrance into the Medicaid system. She recommended the provision of more intensive and/or ongoing respite for unpaid caregivers for an average benefit of $1,200 per year.

9.6 Texas Council of Community Mental Health and Mental Retardation Centers

Susanne Elrod provided written testimony on May 1 on behalf of the Texas Council of Community Mental Health and Mental Retardation (MHMR) Centers, describing the array of respite services offered by Texas' local MRAs. Ms. Elrod explained that GR funding to MRAs to provide respite care has been reduced by $70 million since 2003, greatly affecting their ability to offer these critical services to families in need.

9.7 The Arc of the Capital Area

Susan Eason, Executive Director of the Arc of the Capital Area, provided a written statement prior to the May 1 hearing regarding the benefits of respite services to families caring for children with disabilities. Ms. Eason explained that her daughter has profound intellectual and physical disabilities and described her family's positive experience with a non-profit respite program. She emphasized that families that care for children with

disabilities often become overwhelmed, particularly when they are caring for aging parents as well.

9.8 Austin Travis County Mental Health and Mental Retardation Center

Louise F. Lynch, Director of Developmental Disabilities Services at Austin Travis County Mental Health and Mental Retardation Center (ATCMHMR), provided a written statement prior to the May 1 hearing on behalf of her organization. Ms. Lynch explained that ATCMHMR has served as a provider of or contractor for respite services for children and adults with behavioral health needs, developmental delays, and/or intellectual disabilities for more than 40 years. Ms. Lynch provided several examples of cases in which respite care saved families, promoted resilience, and prevented institutional placements. In one example, she pointed to a 14-year-old girl who was recommended for placement in a state school as a result of cognitive disabilities and behavioral issues. Instead, her family was able to access planned community supports and respite services through ATCMHMR at a cost of $85 per day, compared to $381.20 per day in a state school.

10. List of Acronyms

AAA	Area Agency on Aging
ADRC	Aging and Disability Resource Center
ATCMHMR	Austin Travis County Mental Health and Mental Retardation [center]
CBA	Community-Based Alternatives [waiver]
CLASS	Community Living Assistance and Support Services [waiver]
CMS	Center for Medicare and Medicaid Services
CWP	Consolidated Waiver Program
DADS	Department of Aging and Disability Services
DAHS	Day Activity Health Services
DBMD	Deaf Blind with Multiple Disabilities [waiver]
DRA	Deficit Reduction Act
FPL	Federal Poverty Level
GR	General Revenue
HCS	Home and Community-Based Services [waiver]
HHSC	Health and Human Services Commission
ICF	Intermediate Care Facility
IHFS	In-Home Family Support Services
MDCP	Medically Dependent Children's Program [waiver]
MHMR	Mental Health and Mental Retardation [center]
MRA	Mental Retardation Authority
MS	Multiple Sclerosis
OAA	Older Americans Act
SSI	Supplemental Security Income
TxHML	Texas Home Living Waiver

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CHARGE 6
Examine compliance issues and concerns of hospices with certification surveys and ability to meet federal standards.

In December 2007, committee staff contacted the Department of Aging and Disability Services (DADS), which serves as the regulatory agency for hospice providers. According to research conducted by DADS' staff based on data furnished to the committee, there is no evidence that hospice services have been provided in a manner inconsistent with state and federal standards over the last six fiscal years. DADS' staff concluded, and the committee concurred, that there is no evidence to support significant, systemic regulatory compliance or access-to-care issues for Texas hospices.

Consequently, the House Committee on Human Services did not elicit testimony on Charge 6 during the interim and will not make recommendations related to this charge.

CHARGE 7

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

1. Background Checks for DFPS Employees

In July 2008, the House Committee on Human Services was made aware that at least five current employees of the Department of Family and Protective Services (DFPS) had criminal convictions that should have barred them from employment with the agency.

As authorized by Texas Human Resources Code §40.069, an applicant for temporary or permanent employment with DFPS whose job involves direct interactions with children, or the opportunity to interact and associate with children, is required to submit to a name-based criminal background check with the Department of Public Safety (DPS) and any relevant registries before being employed by the agency. Applicants may not be employed if they have, as an adult or as a juvenile:

- Been convicted of;
- Pleaded guilty to;
- Pleaded no contest to;
- Admitted;
- Had any judgment or order rendered against the applicant;
- Entered into any settlement of an action or claim of;
- Had any license, certification, employment, or volunteer position suspended, revoked, terminated, or adversely affected because of;
- Been diagnosed as having or have been treated for any mental or emotional condition arising from;
- Resigned under threat of termination of employment or volunteerism for;
- Had a report of child abuse or neglect made and substantiated against the applicant for; or
- Have any pending criminal charges against the applicant in this or any other jurisdiction for

one or more of the following:

- Any felony;
- Rape or other sexual assault;
- Physical, sexual, emotional abuse and/or neglect of a minor;
- Incest;
- Exploitation, including sexual, of a minor;
- Sexual misconduct with a minor;
- Molestation of a child;
- Lewdness or indecent exposure;
- Lewd and lascivious behavior;
- Obscene or pornographic literature, photographs, or videos;
- Assault, battery, or any violent offense involving a minor;

- Endangerment of a child;
- Any misdemeanor or other offense classification involving a minor or to which a minor was a witness;
- Unfitness as a parent or custodian;
- Removing children from a state or concealing children in violation of a court order;
- Restrictions or limitations on contact or visitation with children or minors;
- Any type of child abduction; or,
- Similar or related conduct, matters, or things.

DFPS is authorized to conduct criminal history and/or registry clearance checks on any employee at any time the agency deems appropriate. Foster Adoptive Home Development (FAD) workers, who are responsible for recruiting, training, regulating, and assisting foster/adoptive homes, must undergo regular background checks. No other category of DFPS employee is subject to ongoing background checks after the initial check required by statute. Instead, employees must agree to self report any of the following events to their supervisor within five days:

- Arrests;
- Indictments;
- Adjudications of guilt;
- Pleas of guilty or no contest; or
- Assessments of probation, pretrial diversions or community supervision/deferred adjudications for any criminal offenses.*

In cases where DFPS employees do not follow the self-reporting requirement, however, the agency has no way of knowing that the individual in question should be terminated. What's more, DPS name-based criminal background checks do not access criminal records in other states. Consequently, DFPS is recommending that annual background checks be conducted in the future for all employees.†

* For more information regarding DFPS background checks, see Appendix H.

† Texas State Auditor. (2008). *An audit report on human services resource management at health and human services agencies* (Report Number 08-014). Austin, TX.

2. Conclusion and Recommendations
In response to the clear inadequacies of current policy, the House Committee on Human Services offers the following recommendations:

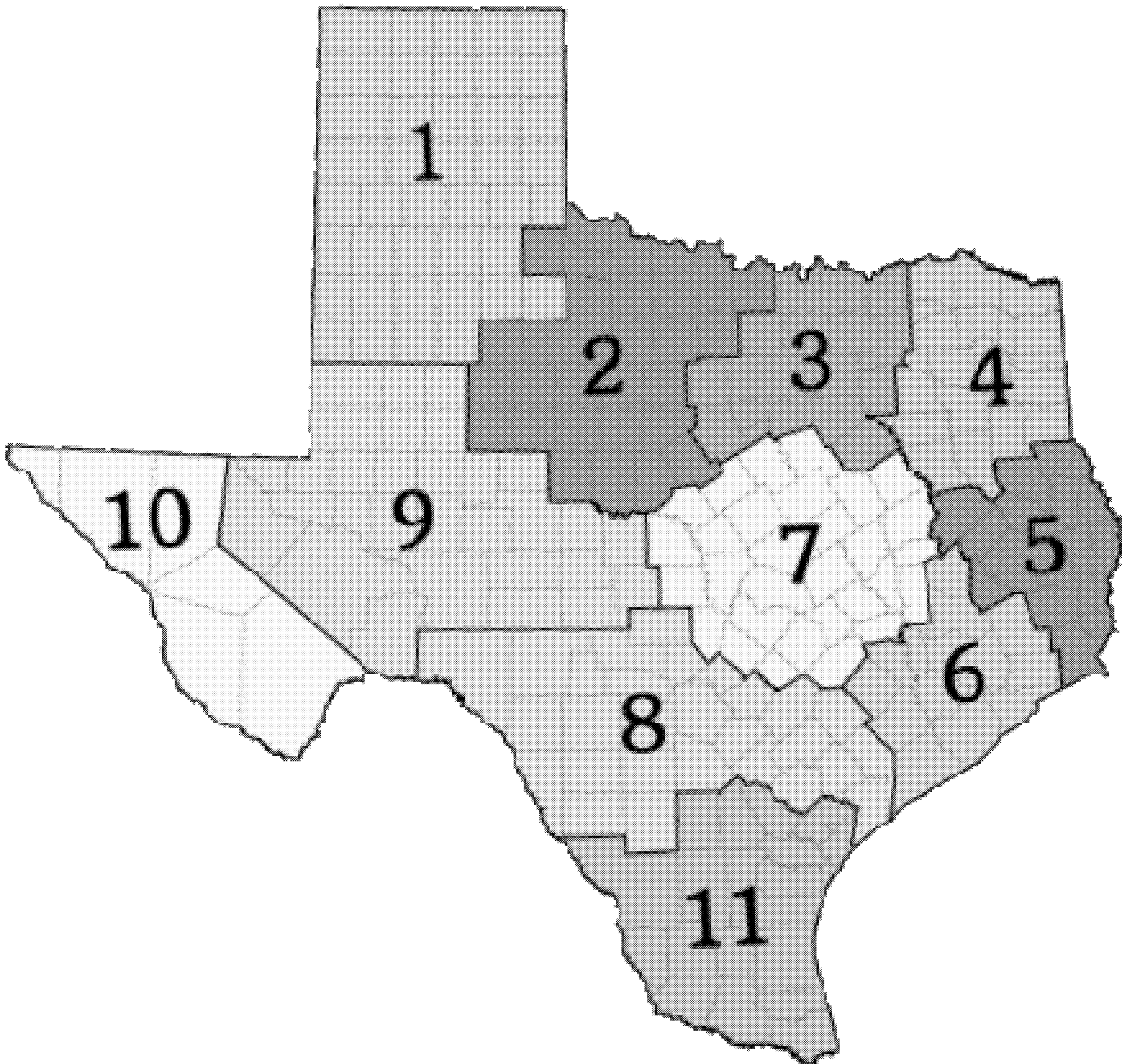
1. **Require that all DFPS employees whose job involves direct interaction with children, or the opportunity to access and or interact with children, submit to a one-time fingerprint background check before employment with the agency. This would allow DFPS to check for criminal history in other states and hold public employees to the same standard required of child-care providers in the private sector.**

2. **Ensure that DFPS is notified of any potential bars to employment while an individual is in the employ of the state by subscribing to the Criminal History Clearinghouse operated by DPS. The Clearinghouse notifies subscribing agencies of any new arrests as they are reported to DPS, precluding the need to run regular background checks after an initial fingerprint check has been conducted.**

3. **Because arrest and disposition data submitted by counties are not always timely and/or complete, require that judges report to DFPS in the event that one of its employees experiences an arrest, indictment, adjudication of guilt, plea of no contest, assessment of probation, pretrial diversion, or community supervision/deferred adjudication for any criminal offense that would bar that individual from employment with the agency.**

4. **Monitor recommendations issued by the Senate Committee on Government Organization, the State Auditor's Office, and DPS regarding any changes needed in the conduct of criminal background checks.**

APPENDIX A: Texas Health and Human Services Regions



Source: Texas Health and Human Services Commission

IN THE SUPREME COURT OF TEXAS

Misc. Docket No. **9193**

ORDER ESTABLISHING PERMANENT JUDICIAL COMMISSION FOR CHILDREN, YOUTH AND FAMILIES

1. Approximately 32,000 Texas children are in the conservatorship of the state, more than ever before, and those numbers are projected to increase. Courts play a critical role in determining these children's future. No child is removed from his or her home, is returned home, or does anything significant in between, without a court order. A judge decides where the child will live, with whom, and for how long. A judge decides whether the child will be allowed to see siblings and other family members, how often, and under what circumstances. A judge approves family service plans and monitors progress to determine whether the family can stay together. And a judge will decide whether a child's relationship with his or her parents will be terminated forever. Clearly, courts have a profound impact on children and families in this state, and the stakes are exceedingly high.

2. Unlike other cases that follow the traditional adversarial process to which civil courts are accustomed, child-protection cases require a collaborative, multi-disciplinary approach. As gatekeepers for families in crisis, courts must make life-altering decisions that require knowledge of multiple and complex issues such as abuse, neglect, substance abuse, family violence, poverty, and mental health. Too often, courts lack the technology, training, and resources needed to make good decisions.

3. Recognizing that judicial leadership at the highest level is needed for systemic improvement, the Supreme Court of Texas began a two-year process to identify problems and consider solutions. Some of the problems identified include the following:

- child-protection dockets are overcrowded, leaving courts inadequate time to thoughtfully consider the multiple issues these cases present;
- there is a lack of communication, coordination, and collaboration between and among the courts, the Department of Family and Protective Services (the "Department"), attorneys, and partners in the child-protection community;
- judges need specialized, multi-disciplinary training, and the means to develop and share best practices;

- courts lack the technology needed to efficiently manage their dockets and to track and analyze child-protection cases and caseloads;

- attorneys representing children, parents, and the Department, need adequate training and fair compensation;

- children in permanent foster care need attorneys and guardians ad litem;

- children , families , and foster parents need to have a voice in decisions that affect their lives and the lives of the children entrusted to their care;

- mediation and non-adversarial family group decision making can be effective means to final resolution and are underutilized throughout the state;

- children in permanent foster care lack adequate family and community support when they age out of the system; and

- communities lack the resources to adequately provide court-ordered services to children , youth and families in the child-welfare system.

4. There are many organizations and individuals throughout the state who share a commitment to improving our child-welfare system, but no single entity is able to coordinate and implement a comprehensive effort aimed at court improvement. Last year, the Court appointed a Foster Care Consultative Group comprised of child-protection experts, and community and state bar leaders, to recommend an effective model for statewide judicial leadership and collaboration. The Consultative Group recommended a plan with a broad range of goals and strategies. The cornerstone of the Group's recommendations was for the Court to create a Permanent Judicial Commission for Children, Youth and Families to serve as the umbrella organization for all efforts to foster court improvement in Texas child-protection cases.

5. On September 25, 2007, the Court held a public hearing to gather further input on the feasibility of a statewide judicial commission. This hearing took place before the Court began hearing arguments in the new term, emphasizing the important role that courts play in the lives of children, youth and families in the child-protection system. National leaders, statewide stakeholders, community volunteers, and a broad array of participants in the child-protection system, including foster youth and families, provided valuable insight at the hearing and voiced unqualified support for the Court's creation of a statewide commission. The Commission would serve as a vehicle for leadership and collaboration to improve the lives and life chances of Texas children who find themselves in the foster-care system through no fault of their own.

The Court, having reviewed the report of the Consultative Group, and having received the endorsement of the Supreme Court Task Force on Foster Care, the Department, community advocates, and participants in the child-protection system, **HEREBY ORDERS:**

1. The Permanent Judicial Commission for Children, Youth and Families (the "Commission") is created to develop, implement, and coordinate policy initiatives

designed to improve courts and court practice for children, youth, and families in the child-protection system.

2. The Supreme Court Task Force on Foster Care, chaired from its inception by The Honorable John 1. Specia of San Antonio, is commended for its many years of outstanding service to the children, youth and families of Texas. This Court recognizes that the Task Force laid the foundation for the Commission and encourages the Task Force members to continue their participation in support of the Commission and its charge. The Task Force will remain intact and continue to oversee the Court Improvement Program ("CIP") until the first business meeting of the Commission, at which time the Task Force's duties will transition to the Commission.

3. The Permanent Judicial Commission for Children, Youth and Families will:

- develop a strategic plan for strengthening courts and court practice in the child protective system;
- identify and assess current and future needs for the courts to be more effective in achieving child-welfare outcomes of safety, permanency, well-being, fairness and due process;
- promote best practices and programs that are data-driven, evidence-based, and outcome-focused;
- improve collaboration and communication among courts, the Department, attorneys, and partners in the child-protection community;
- endeavor to increase resources and funding needed for improvement, and maximize the wise and efficient use of available resources;
- promote adequate and appropriate training for all participants in the childprotection system;
- institutionalize a collaborative model that will continue systemic improvement beyond the tenure ofindividual Commission members; • oversee the administration of designated funds, including the Court Improvement Program grants; and
- provide an annual progress report to the Court.

4. The Commission will consist of no less than fourteen (14) members, to be appointed by the Court, and a Chair, who will be a justice of the Supreme Court. A member of Commission, the Court will designate four (4) members as having a one-year term, four (4) members as having a two-year term, and six (6) members as having a full three-year term. Except for the Chair and the Assistant Commissioner of Child Protective Services, who will be standing members of the Commission, a member

may not be appointed to serve more than two successive full terms. A member who has served two successive full terms is not eligible for reappointment until the first anniversary of the date that the member's last full term on the Commission expired. A vacancy on the Commission is created by three consecutive absences from scheduled Commission meetings, subject to reappointment.

5. Commission members should include members of the judiciary, members of the child-protection system and community, representatives of the business and legal communities, representatives of foundations or organizations with a substantial interest in child-welfare issues, and other state leaders who have demonstrated a commitment to the children, youth and families of Texas. The Commission's membership should also reflect the diverse ethnic, gender, legal, and geographic communities in Texas.

6. The Governor is invited to designate a person to serve as an ex-officio member of the Commission. The Lieutenant Governor and the Speaker of the House are each invited to designate a member of that presiding officer's chamber to serve as an ex-officio member of the Commission. A member appointed by the Governor, Lieutenant Governor or Speaker serves at the pleasure of the appointing officer.

7. The Court recognizes that participation by a broad spectrum of persons involved with the child-welfare system is critical to the Commission's success. Accordingly, the Commission will appoint a multi-disciplinary Collaborative Council whose members may attend Commission meetings and serve on committees as determined by the Commission. The Collaborative Council will include representatives of foster youth and youth advocates, parents and parent advocate groups, attorneys ad litem, community volunteers, child-welfare policy experts, adoption and placement service providers, educators, treatment professionals, and local government.

8. The Commission will maintain three standing committees, with a Commission liaison to each, to implement and oversee the respective federal grants comprising the Court Improvement Program. The standing committees are the Projects Committee, the Technology Committee, and the Training Committee. Each Committee will develop a strategic plan, make sub-grantee recommendations, review program outcomes, review periodic program assessments, promote best practices, and identify and report unmet needs to the Commission, which has final authority and responsibility as to oversight of the federal grants and other Commission projects. The Chair of the Commission will appoint the Committee Chairs and Committee liaisons with the approval of the Commission.

- The Projects Committee should ensure that members of the judiciary with experience presiding over a Child Protective Services docket constitute a majority of its membership.

- The Technology Committee should include members of the judiciary, a representative of the Office of the Attorney General, a representative of the

Department of Family and Protective Services, a representative of the Office of Court Administration, and district clerks from both urban and rural counties. The Task Force on Child Protection Case Management and Reporting will remain intact and continue to oversee the CIP Technology Grant until the Commission appoints the Technology Committee, at which point the Task Force duties will transition to the Technology Committee and the Commission.

- The Training Committee will identify appropriate training priorities and curriculum and will include members of the judiciary, prosecutors, attorneys, and a representative of the Department.

9. The Commission may adopt policies as necessary for the performance of the Commission's duties, and may form new committees or disband existing ones as it deems appropriate.

10. The Honorable Harriet O'Neill, Justice, Supreme Court of Texas, will serve as the Chair of the Permanent Judicial Commission for Children, Youth and Families.

BY THE COURT, IN CHAMBERS, this 20 day of November 2007.

Wallace B. Jefferson, Chief Justice
Nathan L. Hecht, Justice
Harriet O'Neill, Justice
J. Dale Wainwright, Justice
Scott Brister, Justice
David M. Medina, Justice
Paul W. Green, Justice
Phil Johnson, Justice
Don R. Willett, Justice

Source: Permanent Judicial Commission for Children, Youth, and Families

APPENDIX C: Description of Service Levels

Basic Service Level

The Basic Service Level consists of a supportive setting, preferably in a family that is able to maintain or improve the child's functioning. The family should be able to provide:

- routine guidance and supervision to ensure the child's safety and sense of security;
- affection, reassurance, and involvement in activities appropriate to the child's age and development to promote the child's well-being;
- contact, in a manner that is in the best interest of the child, with family members and other persons significant to the child in order to maintain a sense of identity and culture; and
- access on an as-needed basis to therapeutic, habilitative, and medical intervention and guidance from professionals or paraprofessionals to help the child maintain functioning appropriate to the child's age and development.

DFPS Rules, 40 TAC §700.2301

Children Who Need Basic Services

Children who will benefit from basic services are those who are capable of responding to limit-setting or other interventions. Children whose needs are appropriate for basic services may exhibit:

- one or more of the following characteristics:
  - temporary difficulties and occasional misbehavior,
  - brief episodes of acting out in response to stress, or
  - behavior that is minimally disturbing to others, but is considered typical for the child's age and can be corrected; or
- developmental delays or mental retardation whose characteristics include minor to moderate difficulties with conceptual, social, and practical adaptive skills.

DFPS Rules, 40 TAC §700.2303

Moderate Service Level

The Moderate Service Level consists of a structured supportive setting, preferably in a family, in which most activities are designed to improve the child's functioning, including:

- more than routine guidance and supervision to ensure the child's safety and sense of security;
- affection, reassurance, and involvement in structured activities appropriate to the child's age and development to promote the child's well-being;
- contact, in a manner that is in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
- access to therapeutic, habilitative, and medical intervention and guidance from professionals or paraprofessionals to help the child attain or maintain functioning appropriate to the child's age and development.

In addition to the description above, a child with primary medical or habilitative needs may require intermittent interventions from a skilled caregiver who has demonstrated competence.

DFPS Rules, 40 TAC §700.2321

Children Who Need Moderate Services

Children who need moderate services have problems in one or more areas of functioning, including:

- behaviors such as:
  - frequent nonviolent, anti-social acts,
  - occasional physical aggression,
  - minor self-injurious actions, or
  - difficulties that present a moderate risk of harm to self or others;
- abuse of alcohol, drugs, or other conscious-altering substances, and:
  - the extent or frequency of the substance abuse places the child at risk for substantial problems, or
  - a historical diagnosis of substance abuse or dependency requires regular community support through groups or similar interventions;
- developmental delays or mental retardation marked by:
  - moderate to substantial difficulties with conceptual, social, and practical adaptive skills, including daily living and self-care, and
  - moderate impairment in communication, cognition, or expressions of affect; or
- primary medical or habilitative needs including assistance with:
  - occasional exacerbations or intermittent interventions in relation to the diagnosed medical condition,

- limited daily living and self-care skills,
- ambulation, or
- daily access to on-call, skilled caregivers with demonstrated competency.

DFPS Rules, 40 TAC §700.2323

Specialized Service Level

The Specialized Service Level consists of a treatment setting, preferably in a family, in which caregivers have specialized training to provide therapeutic, habilitative, and medical support and interventions including:

- 24-hour supervision to ensure the child's safety and sense of security, which includes close monitoring and increased limit-setting;
- affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;
- contact, in a manner that is in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
- therapeutic, habilitative, and medical intervention and guidance that is regularly scheduled and professionally designed and supervised to help the child attain functioning appropriate to the child's age and development.

In addition to the description above, a child with primary medical or habilitative needs may require regular interventions from a caregiver who has demonstrated competence.

DFPS Rules, 40 TAC §700.2341

Children Who Need Specialized Services

Children who need specialized services have severe problems in one or more areas of functioning, including:

- behaviors such as:
  - unpredictable nonviolent, anti-social acts,
  - frequent or unpredictable physical aggression,
  - marked withdrawal or isolation,
  - major self-injurious actions, including recent suicide attempts, or
  - difficulties that present a significant risk of harm to self or others;
- abuse of alcohol, drugs, or other conscious-altering substances that results in:
  - severe impairment, or
  - a primary diagnosis of substance abuse or dependency;
- developmental delays or mental retardation marked by:
  - severely impaired conceptual, social, and practical adaptive skills, including daily living and self-care,
  - severe impairment in communication, cognition, or expressions of affect,
  - lack of motivation or the inability to complete self-care activities or participate in social activities,
  - inability to respond appropriately to an emergency, or
  - multiple physical disabilities including sensory impairments; or
- primary medical or habilitative needs that require assistance related to:
  - regular or frequent exacerbations or interventions in relation to the diagnosed medical condition,
  - severely limited daily living and self-care skills,
  - ambulation or confinement to a bed, or
  - constant access to on-site, medically skilled caregivers with demonstrated competencies in the interventions needed by children in their care.

DFPS Rules, 40 TAC §700.2343

Intense Service Level

The Intense Service Level consists of a high degree of structure, preferably in a family, to limit the child's access to environments as necessary to protect the child. The caregivers have specialized training to provide intense therapeutic and habilitative supports and interventions with limited outside access, including:

- 24-hour supervision to ensure the child's safety and sense of security, which includes frequent one-to-one monitoring with the ability to provide immediate on-site response;
- affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;
- contact, in a manner that is in the best interest of the child, with family members and other persons significant to the child in order to maintain a sense of identity and culture;

- therapeutic, habilitative, and medical intervention and guidance that is frequently scheduled and professionally designed and supervised to help the child attain functioning more appropriate to the child's age and development; and
- consistent and frequent attention, direction, and assistance to help the child attain stabilization and connect appropriately with the child's environment.

In addition to the description above, a child with developmental delays or mental retardation needs professionally directed, designed, and monitored interventions to enhance:

- mobility;
- communication;
- sensory, motor, and cognitive development; and
- self-help skills.

A child with primary medical or habilitative needs requires frequent and consistent interventions. The child may be dependent on people or technology for accommodation and require interventions designed, monitored, or approved by an appropriately constituted interdisciplinary team.

DFPS Rules, 40 TAC §700.2361

Children Who Need Intense Services

Children who need intense services have severe problems in one or more areas of functioning that present an imminent and critical danger of harm to self or others, such as:

- behaviors that include:
  - extreme physical aggression that causes harm,
  - recurring major self-injurious actions, including suicide attempts,
  - other difficulties that present a critical risk of harm to self or others, or
  - severely impaired reality-testing, communication skills, cognition, expressions of affect, or personal hygiene;
- abuse of alcohol, drugs, or other conscious-altering substances that involves a primary diagnosis of substance dependency in addition to being extremely aggressive or self-destructive to the point of causing harm;
- developmental delays or mental retardation marked by:
  - impairments so severe in conceptual, social, and practical adaptive skills that the child's ability to actively participate in the program is limited and requires constant one-to-one supervision for the safety of self or others, or
  - a consistent inability to cooperate in self-care while requiring constant one-to-one supervision for the safety of self or others; or
- primary medical or habilitative needs that present an imminent and critical medical risk and require assistance with:
  - frequent acute exacerbations and chronic, intensive interventions in relation to the diagnosed medical condition,
  - inability to perform daily living or self-care skills, or
  - 24-hour on-site medical supervision to sustain life support.

Source: Texas Department of Family and Protective Services' Child Protective Services Handbook

APPENDIX D: Personal Home Care Rates, March 2008

State	2008 Minimum Hourly Reimbursement Rate
Texas	**$8.82**
Florida	$9.70
New Jersey	$10.24
Louisiana	$12.00
Maryland	$12.00
Oregon	$12.00
Connecticut	$12.33
Virginia	$12.53
Oklahoma	$12.80
New Mexico	$13.16
Alabama	$13.23
West Virginia	$13.40
District of Columbia	$13.50
Idaho	$13.72
Montana	$13.80
Arkansas	$13.84
Utah	$14.00
Kansas	$14.05
Colorado	$14.28
Rhode Island	$14.36
Ohio	$14.44
North Carolina	$14.88
Washington	$14.93
Maine	$15.14
South Dakota	$15.61
Wisconsin	$15.84
Minnesota	$15.92
Missouri	$16.08
Michigan	$17.21
Tennessee	$17.48
New Hampshire	$17.88
Massachusetts	$18.50
Nevada	$18.50
Indiana	$18.96
Nebraska	$19.51
Alaska	$21.00
Vermont	$24.16
Kentucky	$30.00
New York	$12.82 NY state; $15.18 New York City
California	up to $18.00

Source: Texas Association for Home Care

APPENDIX E: Nursing Facility Closures in Texas, January 2006 - July 2008

FACILITY	CITY	COUNTY	LICENSED BEDS	MEDICAID BEDS	CLOSURE DATE
Country Village Nursing and Rehab	Big Spring	Howard	102	102	7/24/2008
Kermit Health Care	Kermit	Winkler	100	49	7/15/2008
San Saba Nursing Home	San Saba	San Saba	60	36	7/18/2008
Eastland Health Care Center	Eastland	Eastland	100		7/1/2008
Happy Harbor Methodist Home	La Porte	Harris	140		5/8/2008
Resort Lodge	Mineral Wells	Palo Pinto	52	37	4/25/2008
Taylor Care Center	Taylor	Williamson	89	63	4/19/2008
Deport Nursing Home	Deport	Lamar	102		3/26/2008
Rotan Health Care Center	Rotan	Fisher	48	39	2/18/2008
Elgin Golden Years Nursing and Reh	Elgin	Bastrop	90	72	2/17/2008
Country Inn Health Center	Van	Van Zandt			1/4/2008
Roscoe Health Care Center	Roscoe	Nolan	60	60	12/31/2007
Lamesa Health Care Center	Lamesa	Dawson	48	48	12/29/2007
Westwood Nursing and Rehab	Troup	Smith	60	60	12/14/2007
Mayfield Care Center	San Antonio	Bexar			12/1/2007
Community Specialty Hospital	Sherman	Grayson			11/20/2007
Pearsall Nursing and Rehab	Pearsall	Frio	79	64	10/26/2007
Sierra Providnece	El Paso	El Paso	26		10/1/2007
Memorial Herman Spring Shadows	Houston	Harris			11/4/2007
Denver Manor	Wichita Falls	Wichita	81	79	8/18/2007
Holiday Lodge Healthcare Center	Hamlin	Jones	60	60	8/18/2007
Horizon Manor Nursing Home	Nocona	Montague	64	61	8/17/2007
Cedar Falls Care Center	Wichita Falls	Wichita	62	51	8/9/2007
Health South Dallas Transitional	Dallas	Dallas	22		8/8/2007
River Springs Nursing and Rehab	San Marcos	Hays	142		8/8/2007
Rice Springs Care Home	Haskell	Haskell	75	51	7/25/2007
Palo Duro Nursing and Rehab	Amarillo	Potter	120	115	7/21/2007
Cartwheel Lodge of Gonzales	Gonzales	Gonzales	120	107	7/19/2007
Mission Oaks Care Center	Sherman	Grayson	193	193	6/21/2007
Bell County Nursing and Rehab	Temple	Bell	144	125	5/22/2007
Leon Valley Care Center	San Antonio	Bexar	66	63	5/18/2007
Kings Daughetrs Hospital SNF	Temple	Bell	12		4/16/2007
Memorial Hospital Memorial City	Houston	Harris	24		4/1/2007
Park Terrace Nursing and Rehab	Palestine	Anderson	108	87	3/1/2007
Bell Haven Convalescent and Nursing	Killeen	Bell	130	130	2/28/2007
Deer Creek Nursing Center	Nacogdoches	Nacogdoches	68	52	2/22/2007
Southfield Healthcare Center	Pasadena	Harris	187	170	2/9/2007
Medical Center at Terrell Skilled Nursing	Terrell	Kaufman	14	14	1/31/2007
Seton Skilled Subacute Care	Austin	Travis	27		12/31/2006
Elizabeth Bivins Home for the Aged	Amarillo	Potter	38	38	12/14/2006
Nix Medical Center	San Antonio	Bexar	17		12/1/2006
Capitol City Heatlh and Rehab	Austin	Travis	120	120	10/20/2006
Grove Gardens Care Center	Marshall	Harrison			9/25/2006
Bellmead Rehabilitation Center	Waco	McLennan	48	43	9/15/2006

Terrell Manor	Terrell	Kaufman	129		8/23/2006
The Transitional Learning Center	Galveston	Galveston			8/9/2006
Sunview Care and Rehab Center	Corsicana	Navarro	106		7/5/2006
Health South Skilled Rehab Unit of Midland	Midland	Midland	17		6/7/2006
Sycamore Care Center	Fort Worth	Tarrant	48		5/2/2006
Gulf Coast Medical Center	Wharton	Wharton	20		3/15/2006
Heartwood Nursing and Rehab	Taylor	Williamson	116	95	3/3/2006
Huntsville Memorial Hospital	Huntsville	Walker	10		3/1/2006
Northway Health Care	Houston	Harris	158	158	1/26/2006

Source: Texas Health Care Association

APPENDIX F: Evidence-Based Classification System

DFPS will rank Respondents' proposed evidence-based programs based on a four-level classification system developed in conjunction with the U.S. Department of Health and Human Services' Administration for Children and Families, Children's Bureau. Programs proposed in response to this RFP that are determined to rank higher in the four-level classification system's continuum (Level I is lowest, Level IV is highest) will receive a higher score for the corresponding section of the Plan of Operation, Attachment II, than those ranked lower in the classification system's continuum. The four levels of this classification system are discussed in detail below.

Level I – Emerging and Evidence Informed Programs and Practices

This level reflects programs or practices that have a strong theoretical foundation and are considered generally accepted practice for preventing juvenile delinquency. Programs and practices may have been evaluated using less rigorous evaluation designs (e.g. pre- and post-tests, no use of comparison groups), or an evaluation may be in process with results not yet available.

PROGRAMMATIC CHARACTERISTICS

- The program can articulate a theory of change, which specifies clearly identified outcomes and describes the activities that are related to those outcomes. This may be represented through a program logic model or conceptual framework that depicts the assumptions for the activities that will lead to the desired outcomes.
- The program may have a book, manual, other available writings, training materials OR may be working on documents that specify the components of the practice protocol and describe how to administer it.

RESEARCH & EVALUATION CHARACTERISTICS

- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- Programs and practices may have been evaluated using less rigorous evaluation designs that lack a comparison group, including "pre-post" designs that examine change in individuals, from before the program/practice was implemented, to afterward, without comparing to an "untreated" group – or an evaluation may be in process with the results not yet available.

- The program is committed to and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities.
- The practice is generally accepted in clinical practice as appropriate for use with youth in increasing protective factors and preventing juvenile delinquency.

Level II – Promising Programs and Practices

This level reflects programs or activities in which there has been at least one study using some type of control or comparison group and was found to be effective in promoting positive outcomes for youth and preventing juvenile delinquency.

PROGRAMMATIC CHARACTERISTICS

- The program can articulate a theory of change that specifies clearly identified outcomes and describes the activities that are related to those outcomes. This is represented through presence of a program logic model or conceptual framework that depicts the assumptions for the activities that will lead to the desired outcomes.
- The program may have a book, manual, other available writings, and training materials that specifies the components of the practice protocol and describes how to administer it. The program is able to provide formal or informal support and guidance regarding program model.
- The practice is generally accepted in clinical practice as appropriate for use with youth in increasing protective factors and preventing juvenile delinquency.

RESEARCH & EVALUATION CHARACTERISTICS

- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- At least one study utilizing some form of control or comparison group (e.g., untreated group, placebo group, matched wait list) has established the practice's efficacy over the placebo, or found it to be comparable to, or better than, an appropriate comparison practice, in reducing risk and increasing protective factors associated with the prevention of juvenile delinquency. The evaluation utilized a quasi-experimental study design, involving the comparison of two or more groups that differ based on their receipt of the program or practice. A

formal, independent report has been produced which documents the program's positive outcomes.
- The local program is committed to and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities. Programs continually examine long-term outcomes and participate in research that would help solidify the outcome findings.
- The local program can demonstrate adherence to model fidelity in program or practice implementation.

Level III – Supported and Efficacious

This reflects programs or practices with at least two rigorous randomized control trials (or other comparable methodology), which found it to be effective. The program or practice has not been replicated in multiple sites.

PROGRAMMATIC CHARACTERISTICS

- The program articulates a theory of change that specifies clearly identified outcomes and describes the activities that are related to those outcomes. This is represented through the presence of a detailed logic model or conceptual framework that depicts the assumptions for the inputs and outputs that lead to the short, intermediate and long-term outcomes.
- The practice has a book, manual, training, or other available writings that specifies the components of the practice protocol and describes how to administer it.
- The practice is generally accepted in clinical practice as appropriate for use with youth in increasing protective factors and preventing juvenile delinquency.

RESEARCH & EVALUATION CHARACTERISTICS

- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The research supporting the efficacy of the program or practice in producing positive outcomes associated with reducing risk and increasing protective factors associated with the prevention of juvenile delinquency meets at least one or more of the following criterion:
    - At least two rigorous randomized controlled trials (RCTs) in highly controlled settings (e.g., university laboratory) have found the

practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature.

OR

- o At least two between-group design studies using either a matched comparison or regression discontinuity have found the practice to be equivalent to another practice that would qualify as supported or well-supported, or superior to an appropriate comparison practice.

- The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.
- Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.
- If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.
- The program is committed and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities.
- The local program can demonstrate adherence to model fidelity in program implementation.

Level IV – Well-Supported and Effective

This reflects programs or practices with at least two rigorous randomized control trials (or other comparable methodology), which found it to be effective. The program or practice has been replicated in multiple sites.

PROGRAMMATIC CHARACTERISTICS

- The program articulates a theory of change that specifies clearly identified outcomes and describes the activities that are related to those outcomes. This is represented through the presence of a detailed logic model or conceptual framework that depicts the assumptions for the inputs and outputs that lead to the short, intermediate and long-term outcomes.
- The practice has a book, manual, training or other available writings that specify components of the service and describes how to administer it.
- The practice is generally accepted in clinical practice as appropriate for use with youth in increasing protective factors and preventing juvenile delinquency.

RESEARCH & EVALUATION CHARACTERISTICS

- Multiple Site Replication in Usual Practice Settings: At least two rigorous randomized controlled trials (RCT's) or comparable methodology in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, peer-reviewed literature.
- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.
- Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.
- If multiple outcome studies have been conducted, the overall weight of the evidence supports the effectiveness of the practice.
- The program is committed and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities.
- The local program can demonstrate adherence to model fidelity in program implementation.

Through the submission of a logic model and supporting research summaries, Respondents will demonstrate how their program model will produce measurable and preferably sustainable improvements in the lives of at-risk youth they propose serving. Respondents will also demonstrate why the program they plan to implement is the best fit for their proposed target population. Lastly, Respondents will share the measures they plan to utilize in order to ensure fidelity of program implementation for an established model program.

Supportive Information Regarding Evidence-Based Programs and Practices (included later in this Attachment VII) provides links to additional information and current research on evidence-based programs that support the prevention of juvenile delinquency

Source: Texas Department of Family and Protective Services

APPENDIX G: STAR Programs by County, FY 2008

Services To At-Risk Youth (STAR) Program		
Service Provider	**Specific program(s) offered**	**Counties Served**
All Church Home for Children	First Offender Program, Why Try?, Positive Parenting, Parenting Wisely, Fatherhood Development	Hill, Johnson, Palo Pinto, Parker, Tarrant
Anderson Cherokee Community Enrichment Services dba ACCESS	skills-based groups for youth and families using various written materials and videos	Anderson, Cherokee
Andrews Center (Networks STAR)	HYPE (for JD referred youth), Truancy program, Alternative Education Program (AEP) and STAR Group a skills-based groups for youth and families using various written materials.	Henderson, Kaufman, Smith, Van Zandt, Wood
Baptist Children's Home Ministries - Bexar	Solution-focused anger management groups for adults & teens	Bexar
Baptist Children's Home Ministries - Val Verde	Summer youth groups on topics such as self esteem/resiliency, healthy relationships, choices/consequences, substance abuse, stress management, and community pride; UCAP presentations on bullying, child abuse prevention, parent/child communication	Crockett, Kinney, Schleicher, Sutton, Val Verde
Buckner Children and Family Services, Inc. - Rio Grande Valley	Youth groups using Get Real about Violence, It's Up To Me, and Rainbow Days programs. Presentations to parents/adults on child abuse prevention using Parent's Under Construction, WHO, Practical Parenting, Kids Connection/Youth Connection (Rainbow Days), Turning Points	Brooks, Cameron, Hidalgo, Kenedy, Starr, Willacy
Buckner Children and Family Services, Inc. - Southeast Texas	Solution-focused Brief Therapy; Parenting classes using Active Parenting Now, Active Parenting Of Teens, and Fatherhood Development: A Curriculum for Young Fathers; youth groups using Teen Files: The Truth About Violence, The Truth about Sex, and The Truth About Drugs video series, and Volcano in my Tummy for children's groups; also use elements from Youth Connection.	Hardin, Jefferson, Orange
Catholic Family Service, Inc.	Love and Logic, Anger Wranglers, Youth Connection (Rainbow Days)	Bailey, Baylor, Briscoe, Castro, Childress, Cochran, Cottle, Crosby, Dickens, Floyd, Foard, Garza, Hale, Hardeman, Haskell, Hockley, Kent, King, Knox, Lamb, Lubbock, Lynn, Motley, Parmer, Stonewall, Swisher, Terry, Throckmorton, Wilbarger, Yoakum
CCD Counseling, P.A. (Family Tree)	Skills-based programming using various written materials and handouts focusing on such issues as discipline, responsibility, self esteem, anger management; Positive Parenting; Parenting Wisely	Denton
Central Texas Youth Services Bureau	STEP (Systematic Training for Effecitve Parenting), PS I Love You, Parenting the Positive Discipline Way, Anger Management classes (Rethink, Chill Out)	Bell, Coryell, Falls, Freestone, Lampasas, Limestone, McLennan, Milam

Collin Intervention to Youth (dba City House)	Parenting the Strong-Willed Child, For Parent's Sake, Becoming a Love and Logic Parent; Teen Boy Empowerment, Teen Girl Empowerment, 'Tween Girl Empowerment, 'tween Boy Empowerment, Child Empowerment, Parenting 101	Collin, Rockwall
Colorado County Youth and Family Services, Inc. (Youth and Family Services)	Summer Program for youth to learn team builidng skills and social skills; Family Strengthening Workshop for parents to learn parenting skills using Successful Parenting; UCAP Presentations on child abuse prevention and parent/child communicatation; Youth Skills Groups offered to Jr. High Schools for peer advise and group counseling on peer pressures, bullying and current youth issues; Solution Focused Brief Therapy	Austin, Colorado, Fayette
Communities In Schools, Corpus Christi, Inc.	Common Sense Parenting,Youth Connection, Kids Connection, Strengthening Families. In addition, Communities in Schools is an evidence-based program for the prevention of truancy/school dropouts.	Jim Wells, Kleberg, Nueces
Connections Individual and Family Services, Inc.	STEP, Life Skills (Botvin), Youth Connection, Kids Connection, Parent Connection, Strengthening Families, Children in the Middle, Shelter from the Storm, Defiant Children, first Offender Program, Teen Court Program, Assisting Youth to Understand Drugs and Alcohol (AYUDA), Parenting Wisely, Parenting with Dignity, Parenting your Out of control Teenager, Protecting You Protecting Me, Raising Safe Kids (Yellow dino), and various anger management curriculums.	Bastrop, Caldwell, Comal, Gonzales, Guadalupe, Lee, Aransas, Atascosa, Bee, Frio, Goliad, Karnes, Live Oak, McMullen, Refugio, San Patricio, Wilson, Zavala
CrossRoads Youth and Family Services	The Total Transformation Program, STEP- Systematic Training for Effective Parenting, Youth Connection and Kid Connection; youth groups with topics such as anger management, self esteem, stress management, parenting, goal setting, conflict resolution, peer pressure and making good choices.	Calhoun, DeWitt, Jackson, Lavaca, Victoria
Deep East Texas Council of Governments (dba DETCOG)	Parent Effectiveness Training (PET), Active Parenting, Juveniles Against the Madness (JAM), Juvenile Offender Reduction Initiative (Youth Connections)	Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, Tyler
DePelchin Children's Center - Fort Bend (DePelchin Children's Center STAY Program)	Solution-focused Brief Therapy, Parent education, anger management/social skills training.	Fort Bend, Waller
DePelchin Children's Center - Harris (DePelchin Children's Center STAR Program)	Solution-focused Brief Therapy, Parent education, anger management/social skills training. Parenting with Love & Limits	Harris

El Paso Center for Children	Youth Connections (Juvenile Offender Reduction Initiative), Common Sene Parenting, Anger Management classes, Violence Prevention Skills, On Dating, What's up with Bullying.	El Paso
Family Haven Crisis and Resource Center, Inc.	(Parenting with) Love and Logic, Youth Connection, Kids Connection (Rainbow Days), SEALS, Let's Work It Out, The Nine Essentials of a Love and Logic Classroom (pilot project), First Time Offender Groups (topics arranged with JPO)	Delta, Hopkins, Rains
Family Service Center of Galveston County, Texas	STEP Parenting Program; Kids Connection and Youth Connection for groups ages 5-17; Tough Choices (anger management) for teens (in review for use)	Chambers, Galveston, Liberty
Grayson County Juvenile Alternatives, Inc.	Life Skills, Parenting Wisely (Spanish and English), parent support groups; Kids Connection/Youth Connection (Rainbow Days), Active Parenting;	Archer, Clay, Cooke, Fannin, Grayson, Hunt, Lamar, Montague, Wichita, Wise
Greater San Marcos Youth Council, Inc.	Solution-focused Brief Therapy, STEP (both Spanish/English and all age groups), anger management classes	Hays
Harris County Protective Services for Children and Adults	Solution-focused Brief Therapy, Parenting with Love and Limits, Adolescent and Child Component Therapy for Trauma (ACT) Enhanced Services Program, assessment using CAFAS	Harris
High Sky Children's Ranch, Inc. (Stay Together)	Anger Management- "FRED" campaign (Freeze, Relax, Evaluate & Decide), Healthy Supports for Pregnant/Parenting Teens, Camp Watsitumi summer challenge course, Minors in Possession of Alcohol program (MIP), DECISION workshops, Crisis Response Team, Street Outreach Services, youth and family counseling, substance abuse prevention services, child abuse prevention and intervention workshops, BridgeWay - emergency youth shelter, Fairway- transitional living program, community education & outreach.	Andrews, Borden, Brewster, Coke, Concho, Crane, Culberson, Dawson, Ector, Fisher, Gaines, Glasscock, Howard, Hudspeth, Irion, Jeff Davis, Loving, Martin, Midland, Mitchell, Nolan, Pecos, Presidio, Reagan, Reeves, Runnels, Scurry, Sterling, Terrell, Tom Green, Upton, Ward, Winkler
K'STAR, Inc.	parent education classes, parent support group, family matters and Rainbow Days	Bandera, Blanco, Burnet, Edwards, Gillespie, Kendall, Kerr, Kimble, Llano, Mason, Medina, Menard, Real, Uvalde
Montgomery County Youth Services, Inc.	Anger Management- "FRED" campaign (Freeze, Relax, Evaluate & Decide), Healthy Supports for Pregnant/Parenting Teens, Camp Watsitumi summer challenge course, Minors in Possession of Alcohol program (MIP), DECISION workshops, Crisis Response Team, Street Outreach Services, youth and family counseling, substance abuse prevention services, child abuse prevention and intervention workshops, BridgeWay - emergency youth shelter, Fairway- transitional living program, community education & outreach.	Montgomery, Walker

New Horizons Ranch and Center, Inc. (Family First)	Common Sense Parenting, STEP, Nurturing Parent (Dr. Bavolek), First time Offenders program, Solution focused brief therapy, Youth Connections Curriculum, parenting classes, anger management groups, summer programming with collaborating agencies	Brown, Coleman, Jones, McCulloch, Mills, San Saba, Taylor
Promise House, Inc.	Solution-focused Brief Therapy, WHO (We Help Ourselves), STEP, Girl Power, dating violence prevention, anger management, life skills	Dallas
Roy Maas' Youth Alternatives, Inc.	Solution-focused Brief Therapy, parent education classes using Becoming a Love and Logic Parent, Power Source: Taking Charge of Your Life, Family Enhancement Classes	Bexar
Community HealthCore (formerly Sabine Valley)	Channing Bit 6 sessions with video and workbook exercises (anger management), parent education/skills training, parent support groups, youth life skills	Bowie, Camp, Cass, Franklin, Gregg, Harrison, Marion, Morris, Panola, Red River, Rusk, Titus, Upshur
Serving Children and Adolescents in Need, Inc. (SCAN)	Solution-focused Brief Therapy, Botvin's Life Skills, Rainbow Days Kids Connection, Youth Connection, and Family Connection, Parenting: A Skills Training Program and Parenting Adolescents (Dr. Louise Guerney)	Dimmit, Duval, Jim Hogg, La Salle, Maverick, Webb, Zapata
Sherwood and Myrtie Foster's Home for Children, Inc. (Foster's Home Family Care)	parenting classes, Kids Come First (divorce recovery for families), anger management, life skills, bullying prevention, Yello Dyno safety skills/anti-victimization program, Solution-Focused Brief Therapy, Why Try?, Active Parenting Now, Active Parenting of Teens, and 1,2,3,4 Parents!	Bosque, Callahan, Comanche, Eastland, Erath, Hamilton, Hood, Jack, Shackelford, Somervell, Stephens, Young
STARRY	Solution-focused Brief Therapy, Family Forward group (based on Strengthening families), Why Try, Girl Power, Parenting with Success program including parenting skills classes in both English and Spanish, parent support groups, and workshops) grief/loss support group for adults and kids, anger management (Skills for Managing Anger), life skills, STARRY Adventure Club (a social skills group for 7-10 yr. Olds)	Williamson
TEXANA Center	STAND (Supporting Teen Achievements and New Directions) First Time Offenders program, Practical Parenting Program, Love and Logic, Handling Your Anger, Conflict Resolution groups	Matagorda, Wharton
Texas Baptist Home for Children	Why Try? (juvenile offenders program), SCORE truancy camp, parenting groups, conflict resolution, Rainbow Days-Kid's Connection, Youth Connection,Parent Connection. Love Logic	Ellis, Navarro

Texas Panhandle Mental Health/Mental Retardation	3 parenting programs: Back in Control, Common Sense Parenting, and Make Parenting a Pleasure, Shaken Baby Syndrome campaign, bullying presentations, Why Try? Innovative Interventions that Provide Hope and Motive Youth to Overcome Poverty, Violence, ad Failure (one staff has been certified through this program), Helping Kids Heal: Activities to help children recover from trauma & loss by Rebecca Carman, Volcano in my Tummy-helping children handle anger, Rethink & Chill Out- by Irene Newlon, Family Connections, PS I Love You….More by Irene Newton, Paper Dolls & Paper Airplanes,Hot Stuff to help kids chill out, Self-Esteem & Conflict-Solving Activities by Beth Teolis, and Teaching Social Skills to Youth-Dowd & Tierney	Armstrong, Carson, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Potter, Randall, Roberts, Sherman, Wheeler
Twin City Mission	Solution-focused Brief Therapy, STEP, First Offender Program, truancy prevention, life skills, adolescent tobacco cessation/awareness program, anger management, conflict resolution, "How to Talk So Kids Will Listen & Listen So Kids Will Talk," advocacy skills, family assistance program, domestic violence prevention	Brazos, Burleson, Grimes, Leon, Madison, Robertson, Washington
Youth and Family Alliance dba Lifeworks	Solution-focused Brief Therapy, street outreach, Youth Empowerment groups, child abuse prevention groups for parents/adults	Travis
Youth and Family Counseling Services	Solution-focused Brief Therapy, Runaway prevention and intervention, Truancy prevention and counseling, Parenting Classes, teen moms & dads groups, Shaken Baby Syndrome presentations, WHO (We Help Ourselves) presentations, life skills presentations	Brazoria

Source: Texas Department of Family and Protective Services

APPENDIX H: DFPS Memo re. Background Check Policies and Procedures

DFPS Background Checks

DFPS is required and/or authorized to perform background checks for a wide range of persons and activities: these include DPS criminal history checks, FBI fingerprint-based checks, DFPS History Checks, and DFPS Central Registry Checks, with all authority based in Texas Government Code Ch. 411, Sections 114 and 087 and Adam Walsh Child Protection and Safety Act 2006 (Pub.L. 109-248).

DFPS' Centralized Background Check Unit integrates cross-divisional and program policies, procedures, staff, and related resources to provide improved quality, more efficient service, and greater consistency of agency performed or requested background checks where possible. In March 2008, the State Auditor's Office ranked DFPS background check practices and procedures among the highest of all state agencies. While too voluminous and complex to include all particulars here, these practices and procedures are available for examination through DFPS Centralized Background Check Unit, or the State Auditor's Office report.

Key to Background Check Types:

- ***Texas Criminal History Check -*** *a check of Texas Dept. of Public Safety (DPS) records/database.*
- ***DFPS History Check -*** *identifies all case documentation that references the specific person record, regardless of role or relationship.*
- ***DFPS Central Registry Check –*** *The Central Registry identifies persons who have been found responsible for abuse/neglect/exploitation of victims less than 18 years old in CPS, CCL, RCCL or AFC case. In certain circumstances, DFPS record checks may be limited to this scope by statute, due process, or similar.*
- ***FBI Fingerprint Check -*** *FBI fingerprint checks may be requested as a result of statute, regulation, or policy, primarily for case-related, DFPS employment, or Licensing purposes.*

Population Checked	Type of Background Check	Frequency
DFPS Employees and anyone who accesses the DFPS network	Texas Criminal History DFPS History FBI Fingerprint Check, if the applicant has lived outside the state in last 3 years or may have history in another state	Upon employment, and after agency becomes aware of possible criminal conduct
CPS Foster Adoption Development (FAD) staff	• Texas Criminal History • DFPS History • FBI Fingerprint Check, if the applicant has lived outside the state in last 5 years or may have history in another state	Regulations require re-check every 24 months. DFPS chooses to re-check annually
All principals in open cases including Alleged Perpetrators, Prospective Foster Parents, Prospective Relative Placements,	• Texas Criminal History • DFPS History • FBI Fingerprint Check, if the person has lived outside the state in last 3 years or may have history in another state)	During investigation and prior to placement
Adoptive parents, child-placing staff (both CCL & RCCL), including all employees at licensed operations, registered and listed family homes.	• Texas Criminal History • DFPS Central Registry • FBI Fingerprint Check (required on most licensed day care providers and certain foster/adoptive homes under Adam Walsh law and on anyone who has lived outside the state in last 5 years or may have history in another state)	Upon employment at the operation and every 24 months
DFPS Volunteers/Interns (all programs) requesting placement with direct client contact and/or access to client information	• Texas Criminal History • DFPS History	Prior to placement with client contact/information access, and annually thereafter

Population Checked	Type of Background Check	Frequency
Contract providers with direct client contact, including access to client information	• Texas Criminal History • DFPS History	• FBI Fingerprint Check (if the person has lived outside the state in the last 3 years or may have history in another state) Upon employment and every 2 years
External Agency Volunteer Clearance "Big 5": CASA, Child Advocacy Centers, Big Brothers/Big Sisters, Make a Wish (Texas), I Have a Dream (Houston)	• Texas Criminal History • DFPS Central Registry	Upon request
CASA-Travis County Volunteers	• FBI Fingerprint Checks	Upon request
Other Community Service Requests (Any person or group who submits properly notarized request form 2970)	• DFPS Central Registry	Upon request
Expedited Background Checks--CPS Cases: Prospective candidates for emergency/expedited placements.	• Texas Criminal History • DFPS History • FBI Fingerprint Checks (if the person has lived outside the state in the last 3 years or may have history in another state)	As needed for emergency placement situations
All absent parents in cases proceeding to termination of parental rights	• Texas Criminal History	As needed to locate absent parents

Source: Texas Department of Family and Protective Services, August 5, 2008