

II. KEY FUNCTIONS AND PERFORMANCE

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| A. Provide an overview of your agency's mission, objectives, and key functions. |
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Mission

The mission of the Department of State Health Services (DSHS) is to improve health and well-being in Texas.

Objectives

To fulfill its mission, DSHS has the following main objectives.

Improve health status through preparedness and information. To enhance state and local public health systems' resistance to health threats and prepare for health emergencies; to reduce health status disparities; and to provide health information for state and local policy decisions.

Provide infectious disease control, prevention, and treatment. To reduce the occurrence and control the spread of preventable infectious diseases.

Promote health, prevent chronic disease, and provide specialty care. To use health promotion to reduce the occurrence of preventable chronic disease and injury; to administer abstinence education programs; and to administer services related to certain chronic health conditions.

Operate the state public health laboratory. To operate a reference laboratory in support of public health program activities.

Provide primary healthcare and nutrition services. To develop and support primary healthcare and nutrition services to children, women, families, and other qualified individuals through community-based providers.

Provide behavioral health services. To support mental health services and substance abuse prevention, intervention, and treatment.

Build community capacity. To develop and enhance the capacity of community clinical service providers and regional emergency healthcare systems.

Provide state-owned hospital services and facility operations. To provide residential and/or inpatient services to individuals with diagnosed infectious diseases or mental illness through state-owned hospitals.

Provide privately owned hospital services. To provide for the care of persons with mental illness through privately owned hospitals.

Provide licenses and ensure regulatory compliance. To ensure timely, accurate licensing, certification, and other registrations; to provide standards that uphold safety and consumer protection; and to ensure compliance with standards.

Key Functions

DSHS is responsible for oversight and implementation of public health and behavioral health services in Texas. With a budget of \$2.9 billion and a workforce of more than 12,000 in fiscal year 2012, DSHS is the fourth largest of Texas state agencies. DSHS manages nearly 7,900 client services and administrative contracts and conducts business from about 160 locations.

The agency's focus on public health and behavioral health provides DSHS with a broad range of responsibilities associated with improving the health and well-being of Texans. DSHS accomplishes this mission in partnership with numerous academic, research, and health and human services stakeholders within Texas, across the country, and along the United States/Mexico border. The Health and Human Services (HHS) System partners, as listed, perform important roles in working collaboratively to address existing and future issues faced by the agency:

- HHS System agencies;
- DSHS regional offices and hospitals;
- local mental health authorities (LMHAs);
- federally qualified health centers (FQHCs);
- local health departments (LHDs); and
- contracted community service providers.

DSHS promotes optimal health for individuals and communities through the provision of effective public health services, clinical services, mental health services, and substance abuse services. Responsibilities include coordinating a statewide network of services available through DSHS and its partners, ranging from population-based services to individualized care. In its efforts to improve health and well-being in Texas, DSHS performs five key functions, described below.

Prevent and Prepare for Health Threats

DSHS is responsible for improving health and well-being in Texas by implementing programs that identify and decrease public health threats and sources of disease, in addition to enhancing state and local public health systems' resistance to health threats and preparedness for health emergencies. This function includes health promotion and the prevention of environmental and chronic diseases, such as arthritis, asthma, cancer, diabetes, heart disease, and lead poisoning. The function also includes epidemiological studies and health registries designed to provide data and information for the following.

- Assist with policy decisions.
- Address a particular disease.
- Identify cases of disease for public health response, program evaluation, and research.

- Promote surveillance, education, epidemiology, consultation, and intervention for persons with infectious disease.

Build Capacity to Improve Community Health

Through contracts with providers, DSHS seeks to ensure that Texans have access to health services, prevention, and treatment. This includes behavioral health services; primary health care, including direct medical care for women and children with limited resources; public health services; and nutritional services through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). DSHS coordinates the training and certification process for community health workers who provide outreach, health education, and referrals to local community members. Additionally, DSHS provides technical assistance to federal and state-funded loan repayment programs to support the recruitment and retention of physicians in underserved areas. DSHS works to build healthcare capacity in communities by providing technical assistance to organizations applying for certification as FQHCs, emergency medical services (EMS) providers, and state trauma centers. Finally, DSHS works to build community capacity to promote health and prevent chronic and infectious diseases through population-based public health programs.

Promote Recovery for Persons with Substance Use Disorders and/or Mental Illness

DSHS is responsible for improving the health and well-being of Texans across their life span through substance abuse prevention, mental health promotion, and behavioral health treatment to persons with mental illness or substance abuse issues. As the State Mental Health Authority, DSHS manages contracts with 37 LMHAs and 1 behavioral health organization (BHO). DSHS also manages the provision of substance abuse treatment services through contracts with 90 community organizations and 1 BHO.

Provide Inpatient Hospitalization Services

DSHS provides direct services, including inpatient services, at state-administered facilities. These include mental health care provided at nine State Hospitals (Austin, Big Spring, Kerrville, North Texas, Rusk, San Antonio, and Terrell State Hospitals; El Paso Psychiatric Center; and Rio Grande State Center) and the Waco Center for Youth, which provides psychiatric residential services to adolescents. The Texas Center for Infectious Disease provides care for individuals with tuberculosis (TB) and other communicable diseases. The Rio Grande State Center Clinic provides residential services and outpatient primary health care for individuals with intellectual and developmental disabilities.

Protect Consumers through Licensing and Regulatory Services

DSHS seeks to protect the health of Texans by ensuring high standards in the following areas: healthcare facilities, healthcare-related professions (excluding physicians and nurses), EMS providers and personnel, food and food preparation, pharmaceuticals, medical and radiological devices, environmental services to consumers, and consumer products. This function establishes regulatory standards and policies; conducts compliance and enforcement activities; and licenses, surveys, and inspects providers of health care and consumer services.

B. Do each of your key functions continue to serve a clear and ongoing objective? Explain why each of these functions is still needed. What harm would come from no longer performing these functions?

The strategic objectives for DSHS' functions are described below. The following information under each key function justifies their continued need and describes the harm from discontinuing these functions.

Prevent and Prepare for Health Threats

The prevention and preparedness function contributes to the following objectives.

- Enhance state and local public health systems' resistance to health threats and prepare for health emergencies, reduce health status disparities, and provide health information for state and local policy decisions.
- Reduce the occurrence and control the spread of preventable infectious diseases.
- Use health promotion to reduce the occurrence of preventable chronic disease and injury, to administer abstinence education programs, and to administer services related to certain chronic health conditions.
- Operate a reference laboratory in support of public health program activities.

DSHS needs to continue this function to perform the following tasks.

- Identify and prevent potential public health threats in order to reduce incidence of disease and death among Texans.
- Coordinate and enhance the effectiveness of local public health efforts to intervene in the spread of disease at the individual and community level.
- Detect novel diseases and determine disease burden, epidemiology, and disease trends through surveillance systems, disease investigation, and data analysis.
- Reduce disease rates through interventions, such as education, environmental systems, and policy changes.

Without this function, Texas would no longer have the necessary capacity to identify and prepare for potential health threats or reduce the impact of those health threats upon the citizens of Texas. Additionally, the citizens of Texas would be at increased risk for acute and chronic diseases, as well as experience high rates of infectious diseases, resulting in increased incidence of diseases, disparities, deaths, and costs. The detection of and interventions for disease outbreaks and novel diseases would be jeopardized and local response to disease would be less coordinated and efficient. Lack of disease data and guidance from an authoritative source would compromise decisions concerning allocation of limited public health resources.

Build Capacity to Improve Community Health

The community health capacity-building function contributes to the following objectives.

- Develop and support primary healthcare and nutrition services to children, women, families, and other qualified individuals through community-based providers.

- Develop and enhance the capacity of community clinical service providers and regionalized emergency healthcare systems.

This function serves a large population in need of primary healthcare, nutrition services, public health, and clinical services. These functions are essential to support and assist local community capacity for health promotion, and chronic disease prevention.

The breast and cervical cancer mortality rate, the infant mortality rate, and the incidence of infectious diseases and chronic health conditions could increase without this function. DSHS would not be able to detect outbreaks in a timely manner, resulting in increased cases and possibly increased deaths.

Promote Recovery for Persons with Substance Use Disorders and/or Mental Illness

The recovery for persons with substance abuse and/or mental illness function contributes to the following objective.

- Support mental health services and substance abuse prevention, intervention, and treatment.

Without this function, individuals with substance abuse concerns or serious mental illness may not receive appropriate care and treatment in a secure, safe, and therapeutic environment. Additionally, the State would incur additional costs for services provided in other settings, such as the criminal justice system, emergency rooms, or other inpatient hospital settings.

DSHS needs to continue this function to provide community-based prevention, intervention, and treatment services for adults and children affected by substance abuse or mental illness.

Provide Inpatient Hospitalization

The hospital services function contributes to the following objectives.

- Provide residential and/or inpatient services to individuals with infectious diseases or mental illness through state-owned hospitals.
- Provide for the care of persons with mental illness through privately owned hospitals.

DSHS needs to continue this function to provide inpatient services to individuals with the most complicated TB and other infectious diseases who are unable or unwilling to manage the disease in the community. Additionally, the agency still needs to provide inpatient mental health services to individuals who present a substantial risk of serious harm to self or others; evidence a substantial risk of mental or physical deterioration; or, on criminal charge, have been deemed incompetent to stand trial or not guilty by reason of insanity.

Termination of this function would compromise public safety and health. Individuals with complicated infectious diseases or serious mental illness would not receive appropriate care and treatment in a secure, safe, and therapeutic environment, potentially placing the public at risk.

Protect Consumers through Licensing and Regulatory Services

The consumer protection function ensures timely, accurate licensing, certification, and other registrations; provides standards that uphold safety and consumer protection; and ensures compliance with standards.

DSHS needs to continue this function in order to ensure the achievement and maintenance of minimum standards of sanitation, safety, efficacy, and skills for protection of the public health.

Without this function, consumers would no longer have confidence in the food they eat, many of the products and services they purchase, the hospitals and allied healthcare services they use, the drugs they take, or the medical devices they need as part of their clinical care.

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| <p>C. What evidence can your agency provide to show your overall effectiveness and efficiency in meeting your objectives?</p> |
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In addition to the Legislative Budget Board (LBB) approved performance measures, DSHS uses various methods to determine how effective and efficient the agency is at meeting its objectives. The information below describes some of those methods.

Surveys

DSHS uses surveys to obtain customer, stakeholder, and employee feedback and to measure the effectiveness of its programs and services. Examples include the following.

- The Survey of Employee Engagement, administered through the University of Texas Organizational Excellence Group, provides DSHS management with data to analyze work force issues that affect the quality of services, employee satisfaction and retention, and organizational effectiveness.
- The general provisions of the DSHS sub-recipient contracts require contractors to conduct customer service surveys annually. WIC program contractors incorporate the survey results into quality assurance plans to improve customer service. In addition, WIC utilizes the results of the HHSC Report on Customer Service to identify areas for statewide improvement of customer service.
- The Regulatory Services Division (RSD) surveys occupational licensees for feedback on the services provided after completing initial and renewal license applications.
- The Mental Health and Substance Abuse Services (MHSA) Division surveys clients to assess service satisfaction; surveys stakeholders to assess effective communication; and uses surveys to assess public health prevention effectiveness, to measure the prevalence of behavioral health issues, and to determine the need for DSHS-funded services.

Statistics and Performance Measures

In addition to the LBB-approved performance measures, DSHS collects and analyzes a variety of other data to evaluate the effectiveness and efficiency of agency operations. Examples include the following.

- The RSD reviews the number of licenses issued; the number of surveillance activities, surveys, or investigations conducted; and the number of enforcement actions taken to evaluate the amount of work conducted in the programs.
- Some programs within the Family and Community Health Services (FCHS) Division have federal performance measures, such as for the Maternal and Child Health Services Title V block grant. FCHS Division programs also set performance measures for contractors who deliver services.
- The MHSA Division uses data reports, data books, dashboards, and performance assessments to monitor compliance with programmatic and contractual requirements; impact and trend analyses to identify statewide performance trends; and ad-hoc data analyses to determine the impact of proposed federal and state laws.
- The DSHS Laboratory monitors the turnaround time for each of its high volume tests to assure the timely reporting of laboratory reports test results. Untimely test reports could cause delays in patient treatment, case finding, or remediation of contaminated drinking water.

Complaints Data Monitoring

The DSHS Center for Consumer and External Affairs compiles and analyzes monthly performance of various programs' inquiries and complaints. Center staff stores, tracks, and reports data through an electronic system; and generates and disseminates a monthly report to agency leadership to identify challenges and trends.

Independent Audit Results

State agencies and national organizations review DSHS functions to ensure compliance with statutory requirements, federal block grant requirements, and other regulations. Independent audits review compliance with specific programmatic guidelines for a particular state or federal program, state or federal purchasing requirements, and state financial requirements, such as the prompt payment act or cash management. Audits also assess controls over assets or data, including confidential information; processes or activities based upon evaluation of management controls, testing of transactions, and review of evidence; and performance, efficiency, and/or effectiveness of program operations. Several state and federal agencies audit laboratory functions to assure compliance with specific testing requirements. Additionally, peer review audits identify best practices in program operations.

Stakeholder Input

DSHS uses stakeholder input to inform policy decisions, to improve service delivery, and to enhance communication. DSHS encourages stakeholder participation in the Strategic Plan and Legislative Appropriations Request development process. DSHS program areas also seek stakeholder input on specific topics, initiatives, and policy and rule changes. The following list details examples.

- The Local Authority Network Advisory Committee advises HHSC and DSHS on technical and administrative issues that directly affect LMHA responsibilities. The Committee also reviews and makes recommendations regarding current and proposed rules.

- The Council for Advising and Planning (CAP) for the Prevention and Treatment of Mental Health and Substance Use Disorders reviews the MHSA Block Grant Plan and makes recommendations; serves as advocates for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses or emotional problems; and monitors, reviews, and evaluates at least once each year the allocation and adequacy of mental health services within the state.
- The Healthcare-Associated Infections (HAI) and Preventable Adverse Events (PAE) Advisory Panel advises DSHS on the development and implementation of reporting systems to provide information to the public about HAI and PAE in Texas facilities and to inform healthcare choices.
- The Human Immunodeficiency Virus (HIV) Program receives input on policies and priorities from a number of groups. These include the HIV Prevention Community Planning Group, which provides guidance on HIV prevention program policy and priorities; the HIV Medications Advisory Committee, which advises on changes to the medication formulary; the Test Texas HIV Coalition, which promotes inclusion of HIV testing as a part of routine medical care in ambulatory care settings; and the Texas Consortium for Perinatal HIV Prevention, which is dedicated to decreasing perinatal HIV transmission in Texas.
- The Texas Immunization Stakeholder Working Group serves as an advisory group for implementing immunization initiatives. Member organizations also implement action steps to improve immunization services across the statewide system.
- The Public Health Funding and Policy Committee, established by S.B. 969, 82nd Legislature, Regular Session, 2011, provides policy level advice and assistance to DSHS in the organization and funding of local public health in Texas and the relationship between local public health entities and the agency.
- Many regulatory programs receive stakeholder input through advisory committees. DSHS staff incorporates the information generated through this process into the development and revision of rules and standards. The Governor’s EMS and Trauma Advisory Council, the Texas Radiation Advisory Board, and the Youth Camp Advisory Committee meet regularly to discuss pertinent issues and work on specific rule development, standards, or other topics of interest to the groups. Where no advisory committee exists, the program solicits input by identifying and convening key stakeholder groups and the public.
- The State Health Services Council assists the DSHS Commissioner in developing rules and policies. The Council seeks to provide an environment that fosters consumer and constituent input. All meetings are open to the public and the Council accepts public testimony at meetings.

Planning Activities

DSHS conducts planning activities in the development of its Strategic Plan. DSHS conducts additional planning activities in order to be effective and efficient in meeting strategic objectives within the confines of available resources. The following describes these activities.

- DSHS has an internal workgroup that is: identifying, managing, and tracking provisions of federal healthcare reform legislation that are expected to have definite or potential impact to DSHS; estimating impacts to DSHS programs and target populations; and monitoring

potential funding opportunities. DSHS has also charged this workgroup with identifying appropriate existing consumer outreach materials or developing new materials in order to ensure that DSHS clients eligible for the private insurance marketplace receive information about how to access the marketplace. The workgroup is responsible for creating staff development and training materials on the impact of the Affordable Care Act on DSHS programs specifically, and on DSHS program requirements recently passed by the 83rd Legislature, Regular Session, 2013. DSHS is also coordinating with HHSC, the Governor's Office, and the Texas Department of Insurance regarding the research, analysis, planning, and implementation of applicable provisions of the legislation.

- DSHS uses the Maternal and Child Health Title V Five-Year Needs Assessment for program planning and development, effective and efficient implementation, and accurate monitoring of interventions. This assessment determines the needs of women, infants, children, and adolescents, as well as unmet requirements of children and youth with special healthcare needs. For the 2010 Five-Year Needs Assessment submitted with the fiscal year 2011 Title V Block Grant Application, DSHS collected public input to develop recommended needs statements for maternal and child health in Texas and implemented communication strategies to ensure agencywide participation in the process.

Priority Initiatives and Operational Improvements

DSHS maintains a prioritized list of agencywide initiatives and projects. The Commissioner and executive management team, comprised of the Commissioner's direct reports (CDRs), assess the agency's highest priority initiatives according to level of risk, visibility, cost, and service delivery impact. These are designated "Tier 1 Priority Initiatives." DSHS management and staff report on the status of Tier 1 initiatives at least once per quarter at CDR meetings. In 2012, DSHS leadership added operational improvements to the priority projects list, as part of an ongoing quality improvement effort in the agency; these projects improve efficiency and effectiveness of program and administrative operations.

The Commissioner and CDRs meet regularly to provide oversight to priority initiatives; facilitate communication; and discuss, deliberate, and resolve critical issues affecting the agency. Additionally, CDRs hold planning sessions three to four times a year to review accomplishments and develop strategies and activities to improve service delivery, achieve efficiencies, enhance accountability, and address ongoing and future challenges.

Preparedness Exercises

DSHS participates in preparedness exercises to evaluate readiness to respond to all types of public health emergencies or disasters. These exercises assess preparedness capacity and identify areas for improving response to a variety of threats. DSHS conducts exercises annually to test the agency's ability to provide rapid health and medical support for the coastal areas in response to hurricanes. The agency also conducts local and regional exercises each year to test and enhance DSHS' ability to distribute pharmaceuticals, such as antibiotics, rapidly, to large populations. DSHS also participates in annual graded emergency exercises conducted by the Federal Emergency Management Agency at the two nuclear power plants in Texas and at the nuclear weapons stockpile plant near Amarillo. Additionally, DSHS participated in a radioactive

dispersal device exercise in 2009, a waste isolation pilot plant exercise in 2010, and a full-scale exercise conducted by the U.S. Environmental Protection Agency (EPA) with the Centers for Disease Control and Prevention (CDC), the U.S. Food and Drug Administration (FDA), and the U.S. Department of Agriculture (USDA).

Health Status Indicators

DSHS uses health status indicators to demonstrate the overall effectiveness of preventive and primary care and nutritional support services. Examples include:

- reduction in preterm and/or low-birth-weight births to evaluate the provision of prenatal care and nutritional support;
- improvements in child health indicators to evaluate the provision of preventive services such as well-child exams;
- reduction in the rates of substance use/abuse among the primary and secondary target populations to evaluate the effectiveness of the substance abuse prevention or cessation programs; and
- decrease in the rate of vaccine-preventable diseases to evaluate immunization programs.

Accreditation and Certification

DSHS maintains accreditation and certification for some programs and services. DSHS hospitals meet nationally defined standards [Medicare, Medicaid, and The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations)], as well as state-level standards. Compliance with these nationally defined standards not only ensures individuals are receiving clinically appropriate services, but also qualifies the State of Texas to seek reimbursement from Medicare, Medicaid, and other third-party payers for services provided in the state-operated hospitals. Additionally, the FDA has granted DSHS accreditation authority for mammography certification. Under state law, DSHS also is the designated authority for trauma and stroke facilities. The College of American Pathologists accredits the laboratory for compliance with Clinical Laboratory Improvement Amendments regulations, the National Environmental Lab Accreditation Program for compliance with environmental testing guidelines, and other select agents for compliance with specific federal regulations.

Return on Investment (ROI) and Cost-Effectiveness Studies

DSHS uses ROI data to evaluate program effectiveness and efficiency, in addition to planning for new programs and services. Examples include the following.

- DSHS-funded community MHSA services – One ROI study showed the system cost savings of supported housing in the form of rental assistance to persons with serious mental illness who are also homeless. Cost savings include those achieved by offsetting psychiatric hospitalization, crisis services, criminal justice system costs, as well as homeless shelter costs and inpatient hospital costs. Another ROI study showed the system cost savings of establishing more Oxford Houses, evidenced-based supportive, residential settings for individuals in recovery for substance abuse. Cost savings include those achieved from a reduction in treatment relapse, general hospitalization, and unemployment, with an estimated total cost savings of \$3.1 million for 350 clients served annually with the Oxford

House model. DSHS used both ROI studies to support exceptional item funding requests in the 83rd Legislature, Regular Session, 2013.

- DSHS-funded community mental health crisis services – A two-year independent evaluation by Texas A&M University examined the ROI that resulted from redesigning the community mental health crisis system during the 2008-2009 biennium. The findings revealed direct and measurable reductions in the costs associated with crisis redesign that more than covered the cost of the program, even while supporting a 24 percent increase in crisis episodes from 2007 to 2008.
- Hospital services – DSHS sets and assesses performance measures to track the cost-effectiveness of services provided, including the number of inpatient days, average cost of inpatient days, and monthly cost of medications. DSHS has several initiatives to reduce costs and increase cost-effectiveness. These include:
 - monitoring the use of new generation medications to ensure use of the least costly option that meets clinical needs;
 - ensuring patients have an appropriate supply of medications to last until the day of scheduled appointments with community clinicians;
 - implementing residential treatment units within the hospitals to serve patients not in need of the full array of inpatient services, but in need of some level of continued care;
 - contracting with private psychiatric hospitals to serve patients on civil commitments in order to avoid the cost of refurbishing current state-owned buildings or constructing new buildings; and
 - contracting with a Tyler hospital for 30 beds to serve patients who have reduced inpatient needs, but who have medical issues that make them inappropriate for hospital residential units.
- Zoonotic disease intervention – A study by the USDA National Wildlife Research Center found that the DSHS oral rabies vaccination program returned \$3.70 to \$13.44 in benefits for every \$1.00 in program cost, depending upon a range of variables.
- Primary Health Care Program – DSHS projects that the expansion of this program focused on women’s preventive and primary care will achieve annual cost savings totaling an estimated \$87,552,000 relating to the reduction of Medicaid births. The project saves \$1.76 for every \$1.00 spent.

Licenses and Enforcement Actions

DSHS demonstrates effectiveness through the number of licenses and enforcement actions. Compliance and enforcement activities result in the destruction of thousands of pounds of foods, drugs, and devices that are adulterated or unsafe prior to reaching consumers. DSHS also detains imported and domestic products that may be unsafe before they injure or harm consumers. As a result of DSHS regulatory actions, hundreds of healthcare facilities and healthcare professionals have improved their quality of services or lost their licenses to practice. Additionally, dozens of users of radioactive sources have improved their practices, reduced unintended exposure to radiation, and assured the security of radioactive materials.

D. Does your agency’s enabling law continue to correctly reflect your mission, objectives, and approach to performing your functions? Have you recommended changes to the Legislature in the past to improve your agency’s operations? If so, explain. Were the changes adopted?

The agency’s enabling laws continue to reflect DSHS’ mission, objectives, and approach to performing agency functions. The mandates in the Texas Health and Safety Code and the Texas Administrative Code established prior to the consolidation continue to support the agency’s mission, which is to protect and promote the public’s health. As DSHS identifies specific issues, the agency has worked with members of the Legislature on statutory changes to improve operations and efficiencies.

E. Do any of your agency’s functions overlap or duplicate those of another state or federal agency? Explain if, and why, each of your key functions is most appropriately placed within your agency. How do you ensure against duplication with other related agencies?

Legislation in 2003 reorganized the state HHS System to improve client services, consolidate organizational structures and functions, eliminate duplicative administrative systems, and streamline processes and procedures to maximize efficiencies across the agencies. The 2003 legislation realigned operations of the existing 12 HHS agencies by consolidating similar functions within 5 agencies with the express purpose to center service delivery responsibilities in one appropriate agency, rather than offering fragmented services across multiple agencies.

The 2003 legislation consolidated the programs of the Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse, and the Texas Health Care Information Council, as well as the mental health components of programs at TDMHMR. The newly formed DSHS gained responsibility for various statewide services in mental health, substance abuse, public health, and medical care. DSHS recognizes that other state and federal agencies contribute to the agency’s ability to improve health and well-being in Texas; therefore, DSHS actively promotes communication, coordination, and cooperation with these agencies.

Where there is a potential for overlap or duplication of functions, DSHS works with other agencies to define roles and responsibilities, establish agreements, and clarify services and client populations to minimize duplication. The paragraphs below describe supporting detail by function.

Prevent and Prepare for Health Threats

Public health and medical emergency response activities are tiered at the local, regional, state, and federal level. When local areas expend all their resources, the region, then the state, and then the federal government provide support. DSHS not only provides direct support to regions

and local entities, but is also the conduit used by federal partners to channel additional health and medical assets across Texas in times of disaster or emergency.

DSHS is the sole agency in Texas with responsibility for providing statewide disease surveillance; epidemiology; disease investigation, treatment and intervention; and public health follow-up for infectious diseases, such as Human Immunodeficiency Virus (HIV)/acquired immune deficiency syndrome (AIDS), sexually transmitted diseases (STD), and TB. Some LHDs provide these activities in their jurisdictions using federal, state, and/or local resources. Where this is the case, DSHS and LHDs coordinate and collaborate to ensure there is no duplication of services. DSHS also provides resources for HIV, STD, and TB education, prevention, and treatment activities; screening; and testing. CDC directly funds some community-based organizations for similar activities related to HIV prevention; however, these entities provide specific interventions in a limited local area, whereas DSHS provides services statewide.

The Health Resources and Services Administration (HRSA) provides funding authorized through the Ryan White Treatment Extension Act of 2009 to DSHS for the AIDS Drug Assistance Program (ADAP) and for HIV medical and supportive services. DSHS directly administers the ADAP program and directs the HIV medical and supportive services funds to local providers across the state. HRSA also provides Ryan White Program funds directly to the five largest Texas metropolitan areas and to individual clinical agencies. These funds complement funds provided to communities by DSHS for HIV-related medical care. Local plans for DSHS funds must take into account other services available in order to avoid duplication.

Some programs work closely with similar programs in other states during emergencies. For example, the Texas HIV Medication Program activates emergency enrollment procedures to assure uninterrupted continuation of treatment for persons with HIV in other states when emergencies force them to evacuate to Texas. Similarly, when emergencies in other states require the evacuation of persons with TB to Texas, DSHS works with the TB programs in those states to identify the evacuees and their locations. DSHS provides evacuees with temporary supplies of medication and information on the location of TB clinics.

Build Capacity to Improve Community Health

DSHS services to improve community health differ from health services provided by other agencies in that they target prevention and focus on education and provision of technical assistance to providers. Rather than focusing exclusively on providing access to a full range of healthcare services, DSHS programs provide services designed to reach populations, not just individuals, and to prevent disease and minimize the need for future medical interventions. In addition, DSHS population-based programs assist communities in building their capacity to promote health and prevent chronic disease. DSHS communicates and collaborates closely with other HHS agencies; particularly those that serve similar populations and that manage the Medicaid programs. Additionally, the WIC program participates in a coalition with other state programs receiving USDA funding in order to coordinate service delivery and facilitate communication.

Promote Recovery for Persons with Substance Use Disorders and/or Mental Illness

No other state or federal agency functions solely to ensure access to and appropriateness of mental health, substance abuse, tobacco prevention, and tobacco cessation-related services. Some other agencies have funding to support these client services; however, the services are secondary to their main objectives. Other agencies rely on DSHS for clinical expertise in this area or contract for these services within the existing DSHS service infrastructure. For example, the criminal justice system provides treatment services, but often uses DSHS contracted providers and may use DSHS electronic health records to track and monitor service provision.

In 2006, DSHS received a federal President's New Freedom Commission Mental Health Transformation Grant. The objectives of this grant were to reduce fragmentation and build a coordinated behavioral health system that promotes wellness, resilience, and recovery. Representatives from 17 state agencies, legislative representatives, consumers, and family members made up the Transformation Work Group (TWG), which led the transformation initiative, including looking for duplicative or overlapping efforts in mental health services. Upon termination of the grant, DSHS integrated the TWG into the Council for Advising and Planning (CAP) for the Prevention and Treatment of Mental and Substance Use Disorders. The development of the CAP is a funding mandate from the federal agency that oversees MHSA block grants. Seven state agencies are members of CAP and four additional agencies serve as ex-officio members. The purpose of including state agencies is not only to prevent duplication, but also to leverage resources to address all the needs of clients with mental and substance disorders.

Provide Inpatient Hospitalization

The DSHS inpatient facilities serve unique populations and play a unique role in government services. Only individuals with the most severe diagnoses are admitted to state mental health facilities, and DSHS facilities are the providers of last resort. Each State Hospital has a Utilization Management Agreement with the LMHA that they serve. DSHS also has a contract with each LMHA in the state. Both the agreement and the contract require the LMHA to screen persons seeking mental health services to determine if the person requires inpatient psychiatric services.

Protect Consumers through Licensing and Regulatory Services

DSHS' key regulatory functions serve a unique role among the agencies with regulatory responsibilities in that DSHS regulates professions, facilities, environmental practices, and products that affect the health and safety of broad populations of individuals in Texas. DSHS has working agreements and/or contracts and grants that clarify roles and responsibilities with other state or federal agencies to assure no duplication of functions. For example, DSHS coordinates meat safety activities directly with the USDA and performs according to standards that are "at least equal to" the USDA standards. DSHS works closely with many federal agencies, such as FDA, EPA, and U.S. Nuclear Regulatory Commission (NRC), and state agencies such as the Texas Commission on Environmental Quality and Texas Parks and Wildlife Department.

DSHS shares regulatory authority with other state agencies in certain areas. For example, the Texas Department of Agriculture has authority over the quality of eggs through grading, while DSHS checks the storage and temperature of the eggs for safety. Similarly, DSHS and the Texas Animal Health Commission (TAHC) cooperate on protecting human health from animal diseases that are transmissible to people. TAHC monitors and regulates livestock while in the field and up to slaughter, whereas DSHS' responsibilities begin at slaughter and end at sale for consumption by the final consumer.

Ongoing communication between oversight agencies that have cross-jurisdiction with DSHS is a critical aspect of regulatory operations at DSHS. DSHS and the Department of Aging and Disability Services (DADS) both have responsibilities for survey and certification activities; however, each agency has clear responsibility for certain types of facilities. DADS is responsible for the Medicare survey and certification activities in nursing facilities, intermediate care facilities for individuals with intellectual disabilities or related conditions, and home and community support services agencies. DSHS is responsible for survey and certification activities of non-long-term care facilities and coordinates those inspections with Centers for Medicare & Medicaid Services (CMS). In addition, DSHS cooperates with The Joint Commission (TJC), an independent organization that establishes voluntary standards and recommends best practices for inpatient care facilities. CMS accepts TJC accreditation as verification that an inpatient facility meets CMS requirements.

F. In general, how do other states carry out similar functions?

DSHS' functions are similar to those performed by other state health, mental health, and substance abuse departments, but there are also some key differences depending upon the structure and scope of the agency and the relationship with regional, county, and local entities. In some states, the public health, mental health, and substance abuse authorities at the state level are separate agencies. Some states distribute funding directly to counties who, in turn, determine and fund direct care. The following paragraphs describe how, in general, other states carry out DSHS' key functions.

Prevent and Prepare for Health Threats

State health departments typically perform public health prevention functions, such as epidemiology, infectious disease control, and public health laboratory functions. Federal funding sources for these public health functions and for preparedness and response operations provide guidance and requirements that shape the implementation of those activities. The statutory and organizational structure of the health department in each state plays a determining role in how they perform many of these operations. For example, because Texas is a "home-rule" state, the local health officials operate autonomously from, but in partnership with, DSHS. In other states, the health department operations in local communities are in a centralized system, reporting to the state health department directly. These variations in organizational structure affect the methods and performance of these functions.

State health departments typically carry out infectious disease prevention, control, and response, which must respond to federal funding requirements for program oversight and reporting. In other states, LHDs are generally part of the state health department, whereas Texas has a large number of LHDs that are part of independent city or county government structures. The Texas model requires a high level of collaboration and coordination between the state and LHDs. DSHS provides funding for local activities and provides coordination and capacity building support to assure efficient and effective response at a local and community level. DSHS also provides platforms for planning for HIV and STD prevention and care services across funding streams and works with planning and advisory groups and communities to identify and formulate planned responses for the prevention and treatment of these diseases.

Build Capacity to Improve Community Health

The majority of the primary care and preventive health programs receive federal funding; therefore, state health departments across the country carry out the functions in compliance with federal guidelines. Federal guidelines for Title V funds offer states latitude regarding implementation, so states can vary in both types of services provided and methods of service delivery. Family planning and maternal and child health program service delivery varies from state to state, depending on a state's healthcare infrastructure and extent of Medicaid programs. Like Texas, many states deliver the WIC program through local agencies.

Promote Recovery for Persons with Substance Use Disorders and/or Mental Illness

Each state agency receiving federal and state funds for MHSAs services is required to serve priority populations and fulfill the requirements of federal and state funding sources. Some states have attempted to address coordinated and appropriate service delivery and fragmented funding streams through various collaborative initiatives. The Substance Abuse and Mental Health Services Administration (SAMHSA), President's New Freedom Commission Mental Health Transformation Grant encouraged awarded states (of which Texas was one) to focus on the service delivery and financial challenges created by fragmented funding streams and service delivery. SAMHSA structured this grant to affect systems and change processes, which enabled the work of the grant to continue even after the grant funding ended.

Provide Inpatient Hospitalization

Like Texas, the majority of states have state mental hospital systems that provide services for individuals with severe mental illness. The Texas Center for Infectious Disease (TCID) is the only state-funded TB hospital in the nation. Other states have contracted with TCID for services. Depending on the occurrence of TB in other states, they may operate a limited number of beds for the treatment of TB and other infectious diseases within another medical hospital in that state. Federal and other national organizations, such as TJC, provide guidelines or define requirements for facility management in all states with these types of facilities.

Protect Consumers through Licensing and Regulatory Services

In all states, performing the regulatory functions of inspection, licensure, complaint investigation, and enforcement plays a similar role in protecting the public's health; however,

how states organize those functions at the state level varies widely. Texas appears to be unique in the concentration of regulatory functions within the primary public health agency.

Texas is only one of two states that have all food and drug safety programs in the same agency. Other states have the food, drug, seafood, retail, and meat programs in various departments. About 50 percent of the states have their major food programs in departments of health, others are in departments of agriculture, and some are in an agriculture and marketing agency. A few states have these programs in stand-alone agencies.

Texas is unique for the breadth of the environmental programs housed in one agency. Among states with an asbestos program, states that emphasize air quality aspects will place that program in an environmental agency or labor agency, and states that emphasize the worker and public health will place that program in the health agency. Only two states have a mold program. Texas' mold program emphasizes public health; the other state emphasizes consumer protection and that program is in the occupational licensing or labor agency. Lead programs are in health departments in states that have such a program. Most states that have a general sanitation program for public health nuisances place the program either in a public health agency or with a local health department.

There are 35 states, including Texas, that are "agreement states," meaning that the governor has signed an agreement with NRC to the effect that the state will regulate sources, uses, and users of radiation and the NRC will regulate only the nuclear power plants. The remaining 15 states only regulate x-ray and/or naturally occurring radioactive material. Those states with x-ray programs typically place them in the department of health, whereas those with both programs may be in an environmental agency.

G. What key obstacles impair your agency's ability to achieve its objectives?

DSHS continuously seeks to find efficiencies in its business practices to maximize achievement of its strategic objectives; however, DSHS faces challenges, given the breadth and scope of its responsibilities. These challenges fall under three broad categories: workforce, infrastructure needs, and data quality and security. The paragraphs below explain why these areas are obstacles and how DSHS is working to make such obstacles opportunities for future improvements.

Maintaining and Developing the Workforce

Surging population growth, shifting demographic trends, and an aging workforce create challenges in maintaining and developing an efficient, effective, and well-trained workforce, which is vital to protecting and improving the health and well-being of Texans. Potential significant changes in the labor market or in healthcare policy could jeopardize the acquisition, development, deployment, and retention of the DSHS workforce. DSHS will continue to collaborate with institutions of higher education to attract candidates with specialized education and training in public health and behavioral health. The ability to survive

competition in other sectors of the labor market will rest upon comprehensive strategic initiatives and optimizing workforce management.

Clinicians of all types are in short supply nationally and in Texas, but are particularly acute for psychiatrists, child psychiatrists, psychiatric nurse practitioners, psychiatric physician assistants, and licensed substance abuse counselors. General physicians, pharmacists, and dentists are difficult to attract to psychiatric hospitals because of the low base pay and negative perceptions about working in the mental health field. Market forces have increased competition among employers for the limited supply of clinicians available, and have driven up the salaries in these fields. An inability to augment salaries for certification, experience, rural areas, and high-risk duty stations tends to limit an already thin clinician applicant pool. As a result, DSHS contracts with temporary staffing services for physicians and other clinicians, which is very costly. DSHS will continue to request additional resources to recruit and maintain a high caliber workforce in these critical shortage areas.

DSHS will continuously work to align its organizational structure and business processes to accommodate environmental shifts due to health policy changes and funding reductions. The agency will continue to assess the need to realign or consolidate functions, as well as recruit and retain employees with the skills needed to advance public health and behavioral health practice within the state.

Addressing Infrastructure Needs

Ensuring a well-maintained DSHS facilities infrastructure is necessary to provide a safe and secure environment for DSHS clients and workforce. The 10 mental health facilities are campus-style settings composed of over 500 buildings ranging in age from 14 to 154 years, with the majority built between 1930 and 1975. Capital construction funding is necessary to maintain the existing facility infrastructure, meet client service needs, ensure continued accreditation by TJC for federal reimbursement, and reduce maintenance and energy costs. To prepare for the future, each facility will be master planned to identify current and future needs and the most efficient use of the buildings, infrastructure, and land over established time periods. DSHS will gain efficiencies through smaller, consolidated campuses. Planned renovations of existing buildings to meet programmatic needs and increase staff efficiencies, construction of new buildings, and demolition of buildings no longer needed will reduce the overall infrastructure, maintenance, and energy costs. Rider 83 (S.B. 1, Article II, DSHS, 83rd Legislature, Regular Session, 2013) directs DSHS to develop a 10-year plan for the provision of psychiatric inpatient hospitalization. The plan will consider State Hospital system operational needs, including infrastructure needs, capacity needs across various regions of the state, and associated costs.

Repairs are underway on the Robert D. Moreton Building on the DSHS main campus. The exterior skin of the building includes precast concrete panels that have undergone a delayed ettringite formation process causing movement of panels from their installed position. It was determined through an extensive engineering study that the exterior panels of the building had to be re-cladded to prevent interior damages and extend the life of the building. The 82nd

Legislature, Regular Session, 2011, approved a \$20,000,000 exceptional item for building repairs and relocation of staff during the project. DSHS expects construction to be completed by August 2014.

Enhancing Health Data Quality and Security

DSHS has an urgent need to create secure health information systems to support public health activities, improve healthcare quality, and control costs. Technological advances and associated governance structures will be required to address this issue. Additionally, DSHS will need to pursue changes to existing statutes, in order to share data within the agency.

Public health data are critical to health policy decision making. The collection, analysis, dissemination, and reporting functions associated with health data occur throughout DSHS and the HHS System. The DSHS Center for Health Statistics is central to most of the data flows within DSHS. At present, there are statutory provisions prohibiting the linking of hospital discharge data with any other administrative or clinical datasets. This creates a challenge to devise meaningful metrics for quality or patient safety. Vital statistics and other data are at risk for fraud; therefore, data collection and sharing require standards that protect patient privacy, data confidentiality, and system security.

The DSHS statewide information technology (IT) network supports the delivery of public health services to about 160 locations for over 12,000 DSHS employees. IT also supports delivery of WIC participant services to 534 clinics in 227 counties. Over the last four years, DSHS has made significant investment in the network infrastructure to ensure reliability, performance, security, and connectivity redundancy. The agency has implemented cost containment strategies to replace old technology using seat management and leasing strategies with current infrastructure at the desktop. DSHS has enhanced data security through the deployment of infrastructure for e-mail filtering (for the prevention of external attacks such as virus, spyware, malware, and hackers); intrusion detection; software patch management; encryption; and laptop computer tracking. While the agency has accomplished much on the hardware infrastructure initiatives, the remaining challenge is significant.

The strategic focus is shifting to availability, quality, accessibility, security, and sharing of data. DSHS is currently re-engineering or remediating systems to include requirements for web-enabling, standards-based architecture, federal and state rules compliance, and interoperability for data sharing. Strategic initiatives will include evaluations of business intelligence software, e-discovery software, mobile applications strategies, and the use of field data collection and reporting applications utilizing smart phones.

The MHSA Services Division is committed to the data transparency of performance and outcomes of its contracted providers of community MHSA services. As directed by S.B. 126, 83rd Legislature, Regular Session, 2013, and as recommended by the *Comprehensive Analysis of the Public Behavioral Health System*, DSHS will establish (no later than December 1, 2013) and maintain a public reporting system together with the LBB and public input.

A DSHS website will allow external users to view and compare the performance and outcomes of LMHAs, NorthSTAR, and DSHS-funded substance abuse service providers. DSHS will post reports to this website on a semi-annual basis. To the extent possible, outcome measures will capture inpatient psychiatric care diversion, avoidance of emergency room use, criminal justice diversion, and number of persons served who are homeless. DSHS will ensure that the measures reported do not permit identification of individuals.

H. Discuss any changes that could impact your agency's key functions in the future (e.g., changes in federal law or outstanding court cases).

A number of external changes may affect DSHS' key functions, including changes to federal law and court cases. This section addresses these areas.

Federal Legislation and Regulation

Federal Healthcare Reform – On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590), and he signed the Health Care and Education Reconciliation Act of 2010 (H.R. 4872) into law on March 30, 2010. Together, these laws comprise the Affordable Care Act (ACA) and are comprehensive healthcare reforms intended to increase access to health care, provide insurance protections, and improve quality of care. The laws make extensive changes to both public and private insurance plans and practices. The laws will do the following.

- Include a mandate for most individuals to have health insurance.
- Provide states the option to expand Medicaid coverage of certain populations to 133 percent of the federal poverty level (FPL).
- Provide states the option to establish state-based insurance exchanges for individuals and small employers or participate in the federally facilitated private health insurance marketplace.
- Require streamlined eligibility determinations among Medicaid, the Children's Health Insurance Program (CHIP), and private health insurance exchanges.
- Establish new community-based options and programs.
- Provide flexibility for states to change provider reimbursement systems.

By 2019, the Congressional Budget Office estimates that the laws will reduce the number of people without health insurance by 32 million people nationally, at a gross cost of \$940 billion for the healthcare coverage provisions, with projected net savings to the federal government. The federal government anticipates that these laws will reduce the number of uninsured people by mandating coverage, providing subsidies for those under 400 percent FPL, and establishing health insurance exchanges. The mandate and provision of subsidies with affordable insurance available through the federally facilitated marketplace will significantly affect the operations and budgets of DSHS safety net programs.

DSHS is currently working to prepare staff and consumers for the private health insurance marketplace, which the federal government will operate in Texas beginning January 2014. With the availability of subsidies to individuals and families under 400 percent FPL, DSHS safety net programs are preparing for the impact on their populations, services, and operations. In coordination with HHSC and the Texas Department of Insurance, DSHS continues to assess new federal regulations as the federal government releases them, to determine additional impact of the federal law on DSHS programs and operations.

Federal legislation will likely have an impact on health facilities, professions, and products regulated by DSHS. For example, proposed federal law in the food safety area would allow the FDA to share more information and resources with the states, as well as increase required compliance activities and provide the FDA with greater enforcement authority. Additionally, new federal statutes and rules related to pool safety and lead renovation, repair, and painting will impact businesses and individuals. DSHS expects increased inquiries from consumers as changes occur.

Implementation of the Medicaid substance abuse benefit will affect DSHS staff, as well as Medicaid recipients. The Medicaid benefit covers both outpatient and residential services for all Medicaid recipients and will potentially allow DSHS to stretch existing funding further and serve more clients. Additionally, DSHS will need to monitor implementation and provide technical assistance to providers who have questions or encounter billing issues.

U.S. Department of Justice Settlement Agreement – DSHS is a party to a settlement agreement with the U.S. Department of Justice and DADS. The agreement obligates the DADS State Supported Living Center at the RGSC to provide care that meets certain standards, including the manner in which care and treatment are provided, what data are collected, and how it is reported. The settlement agreement requires additional staff to provide care, including professional staff such as psychologists, occupational therapists, physical therapists, and speech therapists. Five reviews have occurred at RGSC since 2010 and the center is making progress toward compliance. During this period, the center has placed 20 individuals in the community.

Litigation

Frew, et al. vs. Janek, et al. – In 1993, the Texas Rural Legal Aid filed a class action lawsuit, now commonly known as *Frew, et al. vs. Janek, et al.* (formerly *Frew, et al. vs. Suehs, et al.*), against the State of Texas alleging that Texas did not adequately provide Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Texas Rural Legal Aid filed the lawsuit on behalf of more than 1.5 million indigent children entitled to health benefits through EPSDT services. The main allegations in the lawsuit include the following.

- Children did not receive medical and dental screenings (check-ups), in accordance with recognized periodicity schedules.
- Texas did not meet the federal screening goals for children.
- Texas did not effectively inform recipients about the benefits of the program.
- Texas did not provide adequate case management services for children.

- The Medical Transportation Program failed to meet the needs of recipients.
- Eligible children did not have access to benefits because of an inadequate supply of providers, which was the result of inadequate reimbursement rates, red tape, and providers' lack of knowledge of the program.

In 1996, the parties entered into a Consent Decree to resolve many of the issues in the suit. The plaintiffs filed a motion to enforce the Decree in 1998 and, in 2000, after hearing evidence on the motion, the court found the State of Texas to be in violation of the Consent Decree and ordered corrective action.

After the State went through all avenues for appeal, the court scheduled a hearing for corrective action for April 2007. Prior to this hearing, both parties negotiated corrective action plans and came to joint agreement on the plans. At a hearing on July 9, 2007, in the U.S. District Court for the Eastern District of Texas, Judge William Wayne Justice found the corrective action plans to be fair, reasonable, and adequate and voiced his intention to order the plans. In September 2007, the court presiding over formerly *Frew, et al. vs. Suehs, et al.* approved 11 agreed corrective action orders (CAOs) to address defendants' violations of the 1996 Consent Decree.

The 80th Legislature, Regular Session, 2007, appropriated an estimated \$1.8 billion for the 2008-09 biennium to support state responsibilities associated with the lawsuit and the CAOs. These orders include, among others, the following obligations.

- Conduct studies of various components of Texas Medicaid, develop corrective action plans to address study findings, and conduct a subsequent study to assess corrective action plans effectiveness.
- Meet stricter call center standards for four toll free numbers.
- Provide specific training to pharmacists and providers.
- Maintain certain contractual standards for managed care organizations.
- Increase Medicaid reimbursement rates to physicians and dentists.
- Implement strategic medical and dental initiatives.

Together, the 11 CAOs require 10 separate studies, each requiring anticipated corrective action and a subsequent study. Several of these studies have been completed, and others are currently underway. Some of the orders also require the parties to agree upon corrective actions plans before the parties implement. Most of the CAOs require studies and/or actions for a certain period of time, after which a "period of conference" between the parties begins. The parties must confer as to what, if any, further action is required. If the parties fail to reach agreement, either party may approach the court for resolution of any dispute(s).

Taylor, et al. vs. Lakey (formerly Fields case) – [Filed by Advocacy Inc. (name changed to Disability Rights Texas) and commonly referred to as "capacity lawsuit."] Criminal defendants are suing the agency in response to their having to wait for what they described as an excessive amount of time between when they are judicially determined to be incompetent to stand trial

and when they are actually admitted to a State Hospital. Disability Rights Texas, who is also a plaintiff in this lawsuit on behalf of all future criminal defendants who are ordered into competency treatment, claims in their pleadings that any delay over three days is a denial of the person's "due-course-of-law" rights under the Texas Constitution.

The 250th District Court issued a ruling on February 2, 2012, that granted Summary Judgment for the plaintiffs, finding that the DSHS practice of placing forensic patients on a waiting list for a period exceeding 21 days prior to admission violates the Texas Constitution. The District Court further gave DSHS a phase-in period in which to implement the new 21-day admission criteria. The agency filed an appeal with the Third Court of Appeals challenging the District Court's ruling, which the court heard on March 27, 2013. The court has not yet issued a ruling on the appeal. An appeal stays the effect of the District Court's order regarding the timelines and implementation schedule set forth in the order.

DSHS is proceeding with its plan to expand State Hospital capacity. Because of internal efforts, no one has been on the maximum-security waiting list over 21 days since March 8, 2013. The first day that no one was on the waiting list for a non-maximum-security bed was May 14, 2013. Since that time, there have only been a few days with patients on the waiting list for a non-maximum-security bed for over 21 days, and then only exceeding the limit by one or two days.

R & H Oil/Tropicana Energy Site – The EPA, the U.S. Defense Logistics Agency, Defense Reutilization and Market Service and other respondents (including DSHS, TCID site) that the EPA has identified as "potentially responsible parties" (PRPs) under the Comprehensive Environmental Response, Compensation, and Liability Act have entered into a settlement agreement. The settlement agreement allows DSHS and the other PRPs to conduct a remedial investigation/feasibility study (RI/FS) that will allow the parties to determine the nature and extent of contamination, identify the proportion of liability attributable to each PRP (including DSHS) for future remediation of the site, and evaluate available remedial alternatives. DSHS has a 1.3 percent level of potential responsibility. EPA executed the agreement with an effective date of March 12, 2010. Pursuant to the settlement agreement, DSHS received payment from the federal government (\$950,000) in April 2010, and the EPA agreed to accept financial assurance of ability to pay the balance of the expected RI/FS costs (originally \$2 million, reduced by \$950,000 to \$1,050,000). Three group members provided assurance adequate to cover this amount. DSHS is not required to provide financial assurance.

Activities under the RI/FS work plan have been ongoing, with regular contact between the EPA and the primary contracting firm, Pastor, Behling & Wheeler, LLC (PBW). On February 29, 2012, PBW met with the EPA to discuss the results of the recent analysis from the RI/FS. The parties discussed the overall project schedule, and EPA agreed that the project was on schedule. EPA related that enough ecological data have been collected that the Screening Level Ecological Risk Assessment (SLERA) can now be prepared. EPA indicated that they would like additional data regarding shallow groundwater and a soil gas sampling near Monitoring Well 9 (MW-9), an offsite monitoring well that is drilled into the deep groundwater. At present, the evidence indicates that no shallow groundwater is at this location. Should these samples confirm that

there are no human exposure pathways, the remedial investigation stage will be considered completed.

Based on PBW's meeting with EPA, DSHS anticipates that PBW will be engaged in the following activities next.

- Install and sample one additional shallow groundwater monitoring well near MW-9 and install and sample a soil gas sample point at the same location.
- Prepare the draft SLERA.
- Prepare the draft RI/FS Report.

Sonogram Lawsuit – Texas Medical Providers Performing Abortion Services, a class represented by Metropolitan OB-GYN, P.A. dba Reproductive Services of San Antonio and Alan Braid, M.D., on behalf of themselves and their patients seeking abortions filed a class action complaint in U.S. District Court, Western District, Austin Division, in June 2011. The suit is a civil rights action challenging the constitutionality of H.B. 15, 82nd Legislature, Regular Session, 2011, which amends the Woman's Right to Know Act, Chapter 171, Texas Health and Safety Code, and requires an ultrasound (sonogram) and certain information be provided to women before performing an abortion. The plaintiffs claim that the Act intrudes on the practice of medicine; imposes strict liability and criminal penalties on physicians; forces physicians to deliver government-mandated speech outside of the accepted standards of medical ethics and practice; and violates the free speech, privacy, equal protection, and due process rights of the physicians and their patients. The plaintiffs seek declaratory judgment, injunctive relief, attorney's fees and costs, and other equitable relief, and have filed for class certification of the lawsuit by the court.

On February 6, 2012, the U.S. District Court granted a motion for summary judgment for the defendants and dismissed the case. DSHS is proceeding with enforcement of the law as a result. On February 10, 2012, the U.S. Court of Appeals denied plaintiffs-appellees petition for rehearing. On February 21, 2012, the defendants filed a motion for attorneys' fees in the amount of \$56,555.40. DSHS filed plaintiffs' motion in opposition on March 6, 2012. The defendants filed defendants' reply in support of attorneys' fees on March 19, 2012. The court issued an **order denying defendants' motion for attorneys' fees on March 28, 2012. The defendants filed defendants' notice of appeal on April 3, 2012.**

I. What are your agency's biggest opportunities for improvement in the future?

Opportunities for future improvement center on enhancing public health response to disasters and disease outbreaks, preventing chronic and infectious diseases, improving the health of infants and women, addressing the evolving profile of individuals in need of DSHS-funded services, meeting increased regulatory demands due to business growth, increasing emphasis on healthcare quality, and developing quality improvement initiatives.

Enhancing Public Health Response to Disasters and Disease Outbreaks

Texas faces many different emergency situations, ranging from hurricanes, floods, and tornados to disease outbreaks. Public health preparedness is the state of being ready for a natural disaster, major incident, disease outbreak, biological attack, or other public health emergency. In a state the size of Texas, with very large and small communities, planning and response activities require close coordination with federal, state, and local jurisdictions. DSHS is the primary agency for coordinating health and medical preparedness and response activities in Texas. This includes activities such as medical evacuations and sheltering of medically fragile individuals, and public communications about personal health protection. Preparedness and response activities must address not only public health and medical services, but also chemical, biological, radiological, and nuclear events. DSHS is exploring the following initiatives to address the response to disasters and disease outbreaks.

- **Public Health Emergency Preparedness and Response** – DSHS coordinates a statewide public and behavioral health preparedness and response program to address the public health and medical response to all hazards, including natural disasters, major accidents, and terrorist acts. DSHS preparedness and response activities rely heavily upon collaborative partnerships with multiple disciplines across a variety of agencies and jurisdictions. DSHS will continue to build local, regional, and state response capabilities and improve plans and procedures for effective response.
- **Epidemiological Surveillance Capacity** – Epidemiology is essential for the detection, control, and prevention of major health problems, in both emergency and non-emergency situations. Effective preparedness and response depends on case reporting of relevant conditions, injuries, exposures, and diseases; detecting significant health threats such as unusual disease clusters; conducting and documenting investigations of outbreaks and acute environmental exposures; and providing public health recommendations to mitigate adverse effects. DSHS will monitor the retention and recruitment of epidemiologists to ensure the capacity to conduct epidemiological surveillance does not decline significantly due to reductions in federal and state funding streams.
- **Outbreak Response** – In response to infectious disease outbreaks, DSHS works in partnership with epidemiologists; laboratorians; public health officials; and many local, state, and federal agencies. DSHS staff investigates outbreaks of food-borne, water-borne, respiratory, and vaccine-preventable diseases. Staff works to ensure rapid detection of an outbreak and a coordinated response. DSHS will continue to refine a structured framework within which the agency effectively investigates outbreaks and brings them under control, and, where possible, takes measures to prevent similar outbreaks in the future.
- **Food Safety** – DSHS estimates that food-borne disease causes approximately 6 million illnesses, 26,000 hospitalizations, and 400 deaths each year in Texas. DSHS has primary responsibility to license and inspect food manufacturers, distributors (including distributors of imported foods), and retailers in Texas; however, not all segments of the food supply chain are adequately regulated. There may be manufacturing, distributing, and/or retail

facilities that are not licensed, whether willfully or through ignorance of the law. When an illness, injury, or outbreak occurs despite best efforts, DSHS has response capabilities using federal, state, and local partnerships to respond quickly to the event, identify the cause, and implement measures to prevent further illness or injury. DSHS will continue to work with partners at all levels to strengthen the food safety system further.

Preventing Chronic Diseases and Infectious Diseases

Chronic and infectious diseases impact thousands of Texans each year. Many of these conditions are exacerbated by behavioral risk factors such as tobacco use, obesity, physical inactivity, consumption of alcohol and other drugs, and poor nutrition. DSHS is exploring the following initiatives to prevent chronic and infectious diseases.

- Tobacco Prevention and Control – DSHS used a statewide strategic planning process that included regional and local stakeholders and partners to develop the goals and objectives that guide the Tobacco Prevention and Control Program. Program goals include preventing initiation of tobacco use, increasing cessation of tobacco use by youth and adults, eliminating exposure to secondhand smoke in public places, and eliminating disparities among diverse and special populations. DSHS will continue to provide program activities at the local level through local community coalitions, regional tobacco program coordinators, and Prevention Resource Center tobacco specialists.
- Obesity Prevention – The Nutrition, Physical Activity, and Obesity Prevention (NPAOP) program supports and promotes projects that focus on the CDC’s six evidence-based target areas for reducing obesity: increasing physical activity; increasing consumption of fruits and vegetables; decreasing consumption of sugar-sweetened beverages; reducing consumption of high-calorie foods; increasing breastfeeding initiation, duration, and exclusivity; and decreasing television viewing. The program targets large segments of the population by promoting strategies to reduce environmental barriers to healthy living and policies that facilitate healthy choices. With CDC funds, NPAOP supports community projects focusing on evidence-based policy and environmental changes and coordination of subject matter expertise; development of the Strategic Plan for the Prevention of Obesity in Texas; and participation and coordination with state partnerships, councils, and groups to enhance statewide efforts toward obesity prevention. The program also sponsors an obesity summit for statewide partners and online professional training modules for physical activity, sustainable agriculture, and breastfeeding.
- Substance Abuse Prevention – Currently, DSHS funds one statewide prevention training services contract and approximately 193 school- and community-based programs to prevent the use and experimentation of alcohol, tobacco, and other drugs (ATOD) among Texas youth and their families. These programs provide evidence-based curricula and five effective prevention strategies in over 500 school districts across the state. The primary population served is youth, ages 0-17, and the secondary population includes the parents and guardians of these youth. Beginning in fiscal year 2014, these services will target youth, ages 6-18, and the secondary population of parents, grandparents, guardians, and siblings

of the youth participants. In addition to these direct services, 11 regional prevention resource centers (PRCs) provide a clearinghouse of information and resources on the harmful effects of ATOD. Beginning in fiscal year 2014, the PRCs will serve as the data collection repository for the regions. The PRCs will develop regional needs assessments that will focus on alcohol (underage drinking), marijuana, prescription drugs, tobacco, and other drugs. Currently, 23 coalitions representing various sectors of the community are located throughout the state. The primary population is adolescents and young adults, ages 18-25, in colleges and universities, and the general community. These coalitions mobilize community stakeholders to address ATOD policy and environmental change.

- HIV Prevention and Control – As the number of Texans living with HIV grows, so do the costs of providing treatment and care. The importance of maintaining programs and access to medical care and adherence services continues as a high priority. Supportive services such as case management, medical transportation, and MESA treatment play key roles in keeping persons with HIV in care and treatment. DSHS will continue to work with communities across Texas to improve the productivity of HIV testing programs by assuring that targeted testing programs focus on groups at highest risk, that providers in health settings in communities of high morbidity establish routine testing, and that public health partner notification programs operate effectively.
- TB Prevention and Control – In 2012, 1,297 cases of TB were reported in Texas, a rate of 4.7 per 100,000 population. TB can strike anyone, but a higher prevalence rate occurs in those born in a foreign country where TB is prevalent, people with diabetes, people with HIV/AIDS, the homeless, and those that work in health care. In order to assure providers promptly identify and report all persons meeting the case definition of suspected or active TB disease, the DSHS prevention and control programs develop and maintain active disease surveillance and promote the use of innovative technologies. Additionally, DSHS programs develop and maintain standard processes to guide outbreak responses and assure that providers identify and screen all persons exposed to TB and, where appropriate, ensure treatment to prevent disease transmission. The programs promote effective treatment modalities that increase compliance among persons diagnosed with latent TB infection and target interventions to populations most at risk for developing TB. In order to assess statewide performance in treating TB, DSHS maintains a robust case management data application.
- Immunizations – Coverage levels for Texas children measured in the National Immunization Survey for 2011 were 74.6 percent. Coverage levels for adults continue to be a challenge. Unlike childhood vaccines that are recommended at specific intervals and ages, the recommendations and licensure for adult vaccines vary over the lifespan. DSHS will continue to support efforts to increase adult immunization rates. To achieve and sustain recent successes, DSHS will continue to promote giving vaccines in the medical home, use the statewide immunization registry, educate providers and the public, and implement reminder/recall systems.

- Medicaid Incentives for Healthy Behaviors – CMS is conducting a grant-funded demonstration to evaluate the effectiveness of providing incentives to encourage Medicaid clients to adopt healthy behaviors and improve outcomes. DSHS and HHSC partnered to receive a \$9.9 million, five-year grant, operated by DSHS. The project, known as Wellness Incentives and Navigation (WIN), focuses on Medicaid managed care (STAR+PLUS) clients with behavioral health conditions. Individuals with these conditions are more likely to suffer chronic physical co-morbidities, experience debilitating chronic physical illnesses earlier in life, and have elevated healthcare costs. WIN has been implemented in the Harris managed care service area, in partnership with the STAR+PLUS health maintenance organizations and other community stakeholders. Interventions, funded by the grant, include wellness planning and navigation facilitated by trained, professional health navigators; flexible wellness accounts for each participant to support specific health goals; and intensive action planning training for individuals with the most severe mental illnesses.

Improving the Health of Infants and Women

Infant and maternal mortality and cancer affect thousands of Texas women and their families each year. Access to appropriate care and education throughout the life course, including preventive and prenatal care and cancer screening and treatment, helps reduce risks and improve outcomes.

Despite major advances in medical care, poor birth outcomes continue to be a problem in the United States and Texas. The leading causes of infant mortality are birth and genetic defects, disorders related to preterm birth and low birth weight, and sudden infant death syndrome (SIDS). Risk factors include no prenatal care, maternal smoking and/or alcohol use, and inadequate weight gain during pregnancy.

The World Health Organization uses maternal mortality as a measure of health and well-being of women across the globe. Researchers at the national and state level have found that maternal mortality is often underreported, particularly deaths of women occurring more than 42 days after the end of a pregnancy, indicating that more could be happening later during the postpartum period than the maternal mortality ratio suggests. Even given potential underreporting, the maternal mortality rate in the United States has nearly doubled in a decade and is higher than in 40 other industrialized countries. In Texas, the rate increased from 8.3 deaths per 100,000 live births in 2000, to 24.6 deaths per 100,000 live births in 2010. Experts do not yet know what has caused the increase in deaths. Potential explanations include the fact more women today are giving birth in their 30s and 40s, when risks of complications during pregnancy and childbirth significantly increase. Almost 25 percent of women of childbearing age are obese and, thus, at higher risk for conditions, such as diabetes and high blood pressure.

Of the leading cancers diagnosed among Texas women, breast cancer is the most common and cervical cancer ranks seventh. Healthcare providers diagnosed an estimated 17,382 women with breast and cervical cancer in 2012, with over 3,200 estimated to die from the disease. Surviving breast and cervical cancer depends on how early the woman detects cancer. The best method to detect breast or cervical cancer in its early stages is through regular screening.

DSHS is exploring the following initiatives to improve the health of infants and women.

- **Healthy Texas Babies** – The Healthy Texas Babies initiative helps Texas communities decrease infant mortality using evidence-based interventions. The initiative, led by DSHS in collaboration with HHSC and the Texas Chapter of the March of Dimes, involves community members, healthcare providers, and insurance companies. Activities focus on educating the public, providers, and patients. Healthy Texas Babies programming includes:
 - evidence-based interventions led by local coalitions in communities identified at high risk for infant mortality and preterm birth;
 - development of a communications campaign to raise public awareness of the factors leading to infant mortality, health disparities, and preterm birth;
 - survey of hospitals to determine where neonatal intensive care units and obstetrical units are in the state and how DSHS can improve access to care for high-risk pregnancies;
 - collaboration between the WIC program and the March of Dimes to improve patient education on the importance of the last weeks of pregnancy;
 - provider education to reduce disparities in birth outcomes between racial and ethnic groups, improve adherence to national standards of care, and provide support for clinical decision making; and
 - increased understanding of how to meet the needs of men in their roles as fathers and support father involvement through evidence-based initiatives.

- **Breastfeeding Promotion** – Breast milk benefits the health, growth, immunity, and development of infants. Mothers who breastfeed have a reduced risk of type 2 diabetes and breast and ovarian cancer. Improving breastfeeding outcomes is integral to DSHS' overall efforts to promote better birth outcomes across the state. DSHS provides education and support through several areas of the agency, including the WIC program. DSHS has numerous breastfeeding activities that are coordinated through the DSHS Infant Feeding Workgroup. DSHS will continue to invest in the following efforts to develop effective interventions: increased awareness of birthing facilities, Better by Breastfeeding/Right from the Start awareness campaign for hospitals, Texas Ten Steps certification program recognizing hospitals that have voluntarily adopted breastfeeding policies, breastfeeding trainings, WIC Every Ounce Counts campaign, Lactation Support Hotline, and Mother-Friendly Worksite initiatives. The initiatives target education of the public, providers, and mothers about the benefits of breastfeeding. DSHS provides support directly to breastfeeding mothers and to birthing facilities and worksites to build an environment around the mother conducive to initiating and continuing breastfeeding.

- **Women's Health** – DSHS will continue to support efforts to decrease maternal mortality rates and ensure women's access to primary and preventive health services throughout the lifespan, including breast and cervical cancer screening through the Breast and Cervical Cancer Screening program. Receiving appropriate services during childbearing years impacts birth outcomes, thus building on the ongoing Healthy Texas Babies initiative. DSHS

will continue to monitor changes in healthcare services and policy and potential impacts on women's health services. The agency will work with stakeholders to identify methods to ensure access to prenatal, preventive, and comprehensive health care, including breast and cervical cancer screening and diagnostic services. Additionally, DSHS will continue to promote local entities' utilization of community health workers to assist women in accessing maternal health and primary and preventive health services.

- Substance Abuse Intervention and Treatment Services for Pregnant and Parenting Women – DSHS funds an array of substance abuse intervention and treatment services designed to meet the special needs of pregnant women and women with dependent children. In addition to admissions prioritization for pregnant and injecting individuals, DSHS has identified individuals involved with the Department of Family and Protective Services (DFPS) as a priority for admission to services. DSHS contracts for specialized services for women and their children in a trauma-informed manner, meaning there is sensitivity to the high incidence of past trauma and abuse affecting this population of women.
 - Pregnant Postpartum Intervention (PPI) services aim to prevent or intervene with substance use/abuse by pregnant and postpartum women in order to improve birth outcomes; reduce the number of infants born with fetal ATOD exposure; and reduce the number of infants exposed to parental substance use/abuse. In addition to providing case management and motivational interviewing services on-site, the PPI provider must also provide outreach services; evidence-based parenting education; education on fetal and child development, family violence and safety, reproductive health, effects of ATOD on fetus; alternative activities that promote mother/child bonding; and home visits, assistance with transportation, and supervision of children as needed.
 - Specialized Female Treatment services include detoxification, residential, and outpatient substance abuse treatment services that are gender-specific. Specialized Female Treatment services include strength-based therapeutic interventions for women that address physical abuse, sexual abuse and relationship issues; evidence-based parenting education; reproductive health education; life skills counseling and education; research-based education on the effects of ATOD on the fetus; and case management services that meet specific needs of this population and their children. Specialized Female Treatment services are also available for pregnant and parenting youth needing outpatient and residential treatment services.
 - Women and Children Services are residential substance abuse treatment services in which the mother resides in a facility with her children during her treatment. DSHS also admits pregnant women in their last trimester to these services and continues their treatment after childbirth. Women enrolled in a Women and Children Services program receive all of the services available in the Specialized Female Treatment program, as well as services provided to their children, including childcare, family activities, and access to services that address needs related to healthy development.

Addressing the Evolving Profile of Individuals in Need of DSHS-Funded Services

As the population of Texas grows and changes in state and federal healthcare policy and resources evolve, the profile of individuals in need of government-funded public health and primary and behavioral health services has shifted.

Public health efforts have contributed to dramatic improvements in well-being and life expectancy during the 20th century. Within that timeframe, the life expectancy of Americans increased by 30 years, from 47 to 77, and 25 of those years are attributable to improvements in public health, rather than improvements in drugs, treatment, and medical care. Immunizations, clean water, clean air, sanitation improvements, and food quality controls have dramatically improved the quality of life for most Americans. Despite these public health improvements, significant health issues remain. Chronic diseases are the leading causes of death in the United States and Texas. Another remaining health issue is infant mortality, which DSHS can address through a number of interventions and population-based efforts. Reduction in the infant mortality rate is a top priority for DSHS, as discussed in the previous section.

Mental illness is a leading cause of disability in the United States, Canada, and Western Europe. In general, 19 percent of the adult population in the United States has a mental disorder alone, during the course of one year; 3 percent have both mental and addictive disorders. In Texas, the 2012 estimated number of adults with serious and persistent mental illness was 496,390. Estimates show that 20 percent of children have mental disorders with at least mild functional impairment. Federal regulations also define a sub-population of children and adolescents with more severe functional limitations, known as “serious emotional disturbance” (SED). Children and adolescents with SED comprise approximately 5-9 percent of children ages 9-17, according to the U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, 1999. The estimated number of children in Texas with SED in 2012 was 175,937.

DSHS is exploring the following initiatives to address the evolving profile of individuals in need of DSHS-funded services.

- Collaboration with LHDs – DSHS is committed to maintaining and enhancing a continuous collaborative relationship with LHDs throughout the state. Specific priority is placed on several initiatives, including the following:
 - supporting the Public Health and Funding Policy Committee;
 - developing plans to transition from contractual agreements with local health entities to cooperative agreements;
 - providing direct support and technical assistance to local health entities by DSHS health service regions to assure seamless and effective delivery of essential public health services to communities in all parts of the state;
 - enhancing education and training programs for local health authorities operating in every Texas county;
 - assuring regular and effective information sharing between DSHS programs and regions with local health entities; and

- facilitating and assisting LHDs seeking accreditation through the national Public Health Accreditation Board.
- Capacity and Utilization of Community-based Behavioral Health, Primary Care, and Public Health Services – DSHS will monitor and assess the impact of the changing healthcare environment on the agency, its programs, service providers, and service recipients. As the safety net system experiences shifts in resources and federal and/or state funding priorities, DSHS will make adjustments accordingly. The agency will make efforts to ensure the availability of public health, primary care, and behavioral health services to populations that may not be eligible for coverage through Medicaid, Medicare, or CHIP. Additionally, DSHS will seek to make available evidence-based service delivery approaches that third-party insurance may not cover, but that, when combined with other treatment methodologies, demonstrate improved health status for service recipients.
- Capacity of Inpatient Psychiatric Hospitals – DSHS operates and maintains state-owned facilities, which provide direct services 24 hours per day, seven days per week to individuals requiring inpatient or residential services. These hospitals serve persons who are involuntarily committed through the Texas court system. DSHS is continually challenged to manage the court commitments made across the state within its bed capacity. In recent years, the State Hospital system has experienced the need for increased capacity mainly due to more patients being committed by the courts and patients requiring increased lengths of treatment. The majority of the increase has been for forensic commitments, patients charged with a crime, and suspected of having or found to have a mental illness that requires treatment or restoration of their competency to stand trial. Because the hospital system has admitted an increased number of patients on forensic commitments and because these patients require a longer stay in the hospital, the State Hospital system has experienced an increased use of resources by the forensic population and a corresponding reduction of beds for civilly committed patients.

From fiscal year 2001 to fiscal year 2013, the percentage of forensic bed use has increased from 16 percent to 43 percent in all State Hospitals. The 419th District Court ruling on the *Taylor, et al. vs. Lakey* lawsuit (addressed in more detail in Question H of this Section) requires DSHS to transfer pretrial detainees confined in county jail prior to being admitted to a State Hospital within 21 days after receiving a commitment order notice from a criminal court. Adjusting to the increasing forensic population has provided numerous challenges and has the potential to change the focus and direction of the State Hospital system. To date, hospitals have added 100 beds to the system by increasing the number of maximum-security beds and contracting with private psychiatric hospitals for increased capacity for civil commitments. DSHS has added beds designated for outpatient competency restoration to the system. Despite efforts to increase capacity and divert treatment when appropriate, the hospital system remains close to capacity, and the trend toward longer-term patients appears to be continuing. Efforts to identify new ways to increase capacity or reduce the need for additional capacity will continue to be necessary to avoid a crisis in availability of inpatient beds.

Meeting Increased Regulatory Demands Due to Business Growth

DSHS regulatory programs ensure that individuals and business entities meet state minimum standards to engage in regulated activities. DSHS licenses health facilities and certain health professionals and regulates manufacturers and processors of consumer products, such as prescription drugs, medical devices, and food and the use of radiation in industry and medical offices. Between 2002 and 2011, all regulatory strategies saw tremendous growth in the number of licensees; the overall increase was about 40 percent, exceeding the growth rate in the state's population. The total number of licenses overseen by DSHS is approaching 425,000.

DSHS anticipates continued growth in the number of licensees, as the state population grows. Additionally, programs added by both federal and state government increase the need for additional licensure, investigatory, and enforcement activities. To keep pace with population growth and the number of licenses, DSHS must recruit trained professionals capable of performing the technical inspections and reviews necessary to protect the health of the state. DSHS regulatory activities impact Texas commerce since regulated individuals cannot work, and regulated firms cannot operate if they do not have statutorily mandated licenses. DSHS must monitor processing times carefully and manage them quickly, if they start to rise. DSHS is exploring the following initiatives to meet increased regulatory demands due to business growth.

- Risk-Based Approach – Historically, DSHS regulatory programs have prioritized inspections, complaint investigations, and other compliance activities to address issues that are of the highest potential public health risk before other issues. With the rapidly growing number of licenses and resource constraints, the risk-based approach is becoming more critical to assure that DSHS uses resources in an efficient and effective manner. Regulatory efforts must remain protective of public health, while still assuring that licenses are issued in a timely manner to allow individuals and businesses to operate. This will mean that DSHS will no longer investigate some low-risk complaints, refer more complaints to entities for self-investigation, and perform fewer routine inspections.
- Aligning Regulatory Resources to Meet Demands – As directed by the 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, DSHS, Rider 59), DSHS initiated an internal self-evaluation of all regulatory programs and functions to identify opportunities for improving the state's regulatory system. The self-evaluation included examination of:
 - the appropriate level of resources, including staffing, required to perform statutorily required regulatory activities;
 - risk matrices for inspections and complaint investigations timeframes;
 - potential administrative efficiencies and opportunities for programmatic restructuring;
 - potential modifications to regulatory functions aimed at prioritizing activities to those of highest risk for the protection of consumers and public health; and

- potential improvements to the ability of the state to recover the costs of performing regulatory services by reducing programmatic costs, reviewing its fee structure, and identifying other potential revenue opportunities.

The report required by Rider 59, *Operational Evaluation of the Division of Regulatory Services at the Department of State Health Services*, includes recommendations for operational improvements. DSHS submitted the report to state leadership in 2013.

Increasing Emphasis on Healthcare Quality

DSHS has been increasingly involved in state efforts to improve the quality and safety of health care in Texas. Currently, DSHS is pursuing multiple initiatives that involve improved healthcare quality and outcomes. DSHS is exploring the following initiatives to increase emphasis on healthcare quality.

- **Adult Potentially Preventable Hospitalizations (PPH) –** Adult Texans experienced approximately 1.4 million PPH from 2006 to 2011. These hospitalizations resulted in approximately \$44.3 billion in hospital charges, approximately \$2,300 for every adult Texan. To assist communities in addressing this issue, DSHS provides information to state, regional, and local stakeholders on the impact of PPH in their geographical area of interest. The following 10 conditions are classified as PPH, because hospitalization would potentially have not occurred if the individual had access to, and/or cooperated with, outpatient health care: bacterial pneumonia, dehydration, urinary tract infection, angina (without procedures), congestive heart failure, hypertension, asthma, chronic obstructive pulmonary disease, diabetes short-term complications, and diabetes long-term complications. The 82nd Legislature, Regular Session, 2011, appropriated \$2 million for DSHS to implement an initiative to reduce PPH in 2012-13 biennium. DSHS successfully executed contracts with 16 counties to target specific PPH conditions. Funded sites are implementing community-coordinated, evidence-based interventions to reduce hospitalizations and/or hospital charges among their adult county residents. In the 2014-15 biennium, DSHS plans to contract with 13 of the 16 counties to continue targeting specific PPH conditions.
- **Healthcare-Associated Infection (HAI) Reporting –** Approximately 130,000-160,000 infections associated with health care are expected to occur annually in Texas at an estimated cost as high as \$2 billion. Senate Bill 288, 80th Legislature, Regular Session, 2007, required DSHS to establish an HAI reporting system. In addition, this legislation charged DSHS with developing and publishing a summary of the infections reported by healthcare facilities, establishing an advisory panel, providing education and training for healthcare facility staff, and providing accurate comparison of HAI data to the public to help individuals make informed decisions about choosing healthcare facilities.
- **Preventable Adverse Events (PAEs) Reporting and Patient Safety –** Senate Bill 203, 81st Legislature, Regular Session, 2009, requires the reporting of PAEs. CMS has established 10 categories of hospital-acquired conditions (HACs) for which the Medicare program will not provide additional payment to the facility, if the condition was not present on admission.

Examples of HACs include catheter-associated urinary tract infections, deep vein thrombosis following certain orthopedic procedures, and surgical site infections following bariatric surgery for obesity.

The National Quality Forum (NQF) has identified 29 serious reportable events, known as “never events.” Examples of never events include unintended retention of a foreign object in a patient after surgery; surgery performed on the wrong body part; surgery performed on the wrong patient; patient death or serious disability associated with a medication error; and patient death or serious disability associated with a fall while being cared for in a healthcare facility.

The patient safety initiative includes development of a secure, web-based reporting system for over 1,000 hospitals and ambulatory surgery centers to report the NQF serious reportable events identified. The system developed for PAE will also enable hospitals to report HACs or events for which the Medicare program will not provide additional payment to the facility. The initiative includes development of a website to display incidence of PAE by hospital and surgery center.

Developing Quality Improvement Initiatives for Key Business Processes

Improving key business processes is a critical ongoing activity for DSHS employees. DSHS has developed business processes to meet the goals and objectives of the agency established by the Texas Legislature and, in many cases, by laws and rules established by federal agencies. DSHS continuously seeks to find efficiencies in its business practices to maximize achievement of its mission. DSHS is reviewing key business processes in order to contain costs, improve efficiencies, streamline procedures and systems, and enhance performance. DSHS is exploring the following initiatives to improve key business processes.

- **Public Health Improvement Initiative** – In 2010, Texas received a National Public Health Improvement Initiative (NPHII) grant from the CDC to transform the Texas public health system and increase performance management capacity. The NPHII grant has a five-year timeline for implementing quality improvement (QI) activities. DSHS formed a QI team to support the grant and develop an agencywide quality improvement plan. The team conducted an initial quality improvement self-assessment and QI training. Following are some of the activities, to date.
 - **Quality Champion Training:** To support the expansion of QI knowledge across the agency, DSHS designed the training program to bring skills development directly to program staff. The agency selected 60 participants as Quality Champions to participate in four days of training provided by the Public Health Foundation. Participants worked in teams to complete QI projects for their division over the course of the training program.
 - **QI Network Interest Survey:** DSHS designed and sent a short survey to approximately 250 employees to determine staff interested in ongoing QI training. Based on the survey results, staff demonstrated a strong interest to attend bimonthly webinars on QI tools, QI project updates, and article discussions. Notably,

74 percent of respondents said they would be willing to lead a training discussion now or in the future.

- Return on Investment (ROI) Training: The CDC NPHII staff attended ROI training in Dallas with other Texas CDC NPHII Performance Improvement Managers. Additionally, the Texas Public Health Training Centers provided ROI training for 40 employees using tuberculosis as the example.
 - Additional QI Initiatives: Additional efforts include the development of QI webpage for the agency; contract streamlining; development of key performance indicators for the purposes of developing an agency performance measures dashboard; a LHD survey of accreditation readiness and a LHD training toolkit for accreditation; and the development of a health status indicator website.
- Contract Process Improvement Initiative – The goal of the Contract Improvement Initiative is to make the agency’s contracting process easier and faster, with a target of at least a 25 percent reduction in the cycle time for contracts and resulting cost savings. The Contract Improvement Initiative enabled a comprehensive mapping of the contracting process. The implementation plan includes the following recommendations, which are being phased in beginning January 2012:
 - proposed adoption of revised contracting process beginning in the fiscal year 2014 contracting period;
 - use of an electronic contracting system and contractor portal that is currently used by another state agency;
 - continuous evaluation of implementation by Internal Audit; and
 - review of opportunities to consolidate functions and duties across the agency, once the system is in place.
 - Cost Containment Initiatives – DSHS continues to evaluate opportunities to contain costs. During the 82nd Legislature, Regular Session, 2011, DSHS created residential rehabilitation units as a potential cost containment strategy. DSHS converted 40 acute/sub-acute beds at each of three hospitals (Big Spring State Hospital, Rusk State Hospital, and San Antonio State Hospital) to residential rehabilitation units. Cost savings resulted, because the staffing required for a residential rehabilitation unit is less than is required for an acute/sub-acute unit.

DSHS has also initiated efforts to reduce medication costs. Hospitals have reduced discharge medications from a two-week supply to a one-week supply. Patients receive prescriptions that they can fill at local pharmacies or LMHAs. Additionally, the clinical director at each hospital receives a report that details the prescribing practices of each psychiatrist. The director consults with individual psychiatrists concerning their prescribing practices, with particular focus on the use of multiple medications, use of new generation medications, and use of generic versus brand medications. The resulting changes in prescribing practices, combined with generic versions becoming available for several high cost medications, have resulted in a significant decrease in medication costs at the hospitals.

J. In the following chart, provide information regarding your agency's key performance measures included in your appropriations bill pattern, including outcome, input, efficiency, and explanatory measures.

| Texas Department of State Health Services Exhibit 2: Key Performance Measures — Fiscal Year 2012 | | | |
|---|---------------------------|---|---|
| Key Performance Measures | FY 2012 Target | FY 2012 Actual Performance | FY 2012 % of Annual Target |
| Number of Educational Hours Provided on Bioterrorism and Preparedness | 34,500 | 11,952 | 34.64% |
| # of Vaccine Doses Administered – Children | 14,576,225 | 12,891,362 | 88.44% |
| # of Persons Served by the HIV Medication Program | 15,672 | 28,235 | 109.97% |
| # of Communicable Disease Investigations | 125,000 | 59,516 | 47.61% |
| # of Diabetes-related Prevention Activities | 350,000 | 277,962 | 79.42% |
| #of Persons Served in Abstinence Education Programs | 5,322 | 48,112 | 904.02% |
| # of Kidney Health Clients Provided Services | 18,313 | 19,563 | 106.83% |
| Avg. Monthly Caseload for Children with Special Healthcare Needs Receiving Healthcare Benefits | 1,000 | 1,126 | 106.83% |
| # of WIC Participants Provided Nutritious Food Supplements | 1,031,671 | 965,249 | 93.56% |
| # of Infants <1 and Children Age 1-21 Years Provided Services | 30,223 | 36,482 | 120.71% |
| # of Women over 21 Provided Title V Services | 18,687 | 16,873 | 90.13% |
| # of Adults and Adolescents Receiving Family Planning Services | 61,135 | 75,160 | 122.94% |
| # of Primary Healthcare Eligible Patients provided Primary Care Services | 65,000 | 64,338 | 98.98% |
| Avg. Monthly # of Adults Receiving Community Mental Health Services | 52,484 | 51,140 | 97.44% |
| Avg. Monthly # of Persons Receiving Community Mental Health New Generation Medications | 21,000 | 18,588 | 88.51% |
| Avg. Monthly # of Children Receiving Community Mental Health Services | 12,206 | 13,300 | 108.96% |

Texas Department of State Health Services
Exhibit 2: Key Performance Measures — Fiscal Year 2012

| Key Performance Measures | FY 2012 Target | FY 2012 Actual Performance | FY 2012 % of Annual Target |
|---|----------------|----------------------------|----------------------------|
| # of Persons Receiving Crisis Residential Services | 16,647 | 21,524 | 129.30% |
| # of Persons Receiving Crisis Outpatient Services | 59,935 | 67,531 | 112.67% |
| Avg. Monthly # of Adults Served in Substance Abuse Prevention Programs | 29,000 | 36,533 | 125.97% |
| Avg. Monthly # of Youths Served in Substance Abuse Prevention Programs | 106,640 | 154,728 | 145.09% |
| Avg. Monthly # of Adults Served in Substance Abuse Intervention Programs | 12,495 | 10,994 | 87.98% |
| Avg. Monthly # of Youths Served in Substance Abuse Intervention Programs | 4,467 | 3,962 | 88.70% |
| Avg. Monthly # of Adults Served in Treatment Programs for Substance Abuse | 5,360 | 7,405 | 138.15% |
| Avg. Monthly # of Youths Served in Treatment Programs for Substance Abuse | 750 | 1,236 | 164.79% |
| # of Texas Communities Implementing Comprehensive Tobacco Prevention Programs | 7 | 7 | 100% |
| # of Inpatient Days, Texas Center for Infectious Disease | 12,327 | 15,173 | 123.09% |
| # of Outpatient Visits, South Texas Healthcare System | 51,100 | 38,189 | 74.73% |
| Avg. Daily Census of State Mental Health Facilities | 2,477 | 2,310 | 93.24% |
| Avg. Monthly # of State Mental Health Facilities' Consumers Receiving New Generation Medications | 2,583 | 2,370 | 91.76% |
| Avg. Daily # of Occupied Mental Health Community Hospital Beds | 301 | 285 | 94.55% |
| # of Providers Funded – EMS/Trauma | 2,587 | 2,523 | 97.53% |
| # of Healthcare Professionals and Licensed Chemical Dependency Counselors Licensed, Permit, Certified, Registered | 92,000 | 98,344 | 106.90% |
| # of Sex Offenders Provided Treatment and Supervision | 139 | 158 | 113.67% |

**Texas Department of State Health Services
Exhibit 2: Key Performance Measures — Fiscal Year 2012**

| Key Performance Measures | FY 2012 Target | FY 2012 Actual Performance | FY 2012 % of Annual Target |
|--|----------------|----------------------------|----------------------------|
| Avg. # of Days to Certify or Verify Vital Statistics Records | 14 | 11 | 79.29% |
| Avg. Monthly Cost per Adult – Community Mental Health Services | \$361 | \$365.65 | 101.29% |
| Avg. Monthly Cost per Person – New Generation Medications | \$140 | \$157.79 | 112.71% |
| Avg. Amount of General Revenue Spent per Person for Crisis Residential Services | \$2,500 | \$2,199.5 | 87.96% |
| Avg. Amount of General Revenue Spent per Person for Crisis Outpatient Services | \$800 | \$639.31 | 79.91% |
| Avg. Daily Cost per Occupied State Mental Health Facility Bed | \$401 | \$420.25 | 104.80% |
| Avg. Monthly Cost per State Mental Health Facility Consumer Receiving New Generation Medications | \$609.82 | \$463 | 75.92% |
| Avg. Daily Cost per Mental Health Community Hospital Bed | \$483 | \$469.77 | 97.26% |
| Avg. Cost per Surveillance Activity – Food (Meat) and Drug Safety | \$178 | \$273.64 | 153.73% |
| Avg. Cost per Surveillance Activity – Environmental Health | \$151 | \$182.21 | 120.67% |
| Avg. Cost per Surveillance Activity – Radiation Control | \$298 | \$291 | 97.65% |
| Avg. Cost per Sex Offender for Treatment and Supervision | \$29,048 | \$22,110 | 76.12% |

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