TEXAS
Health and Human
Services System

Health and Human Services System Strategic Plan 2017–2021

Volume II

Health and Human Services Commission

Department of Family and Protective Services

Department of State Health Services

Available at:
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Texas Health and Human Services System Strategic Plan 2017–2021

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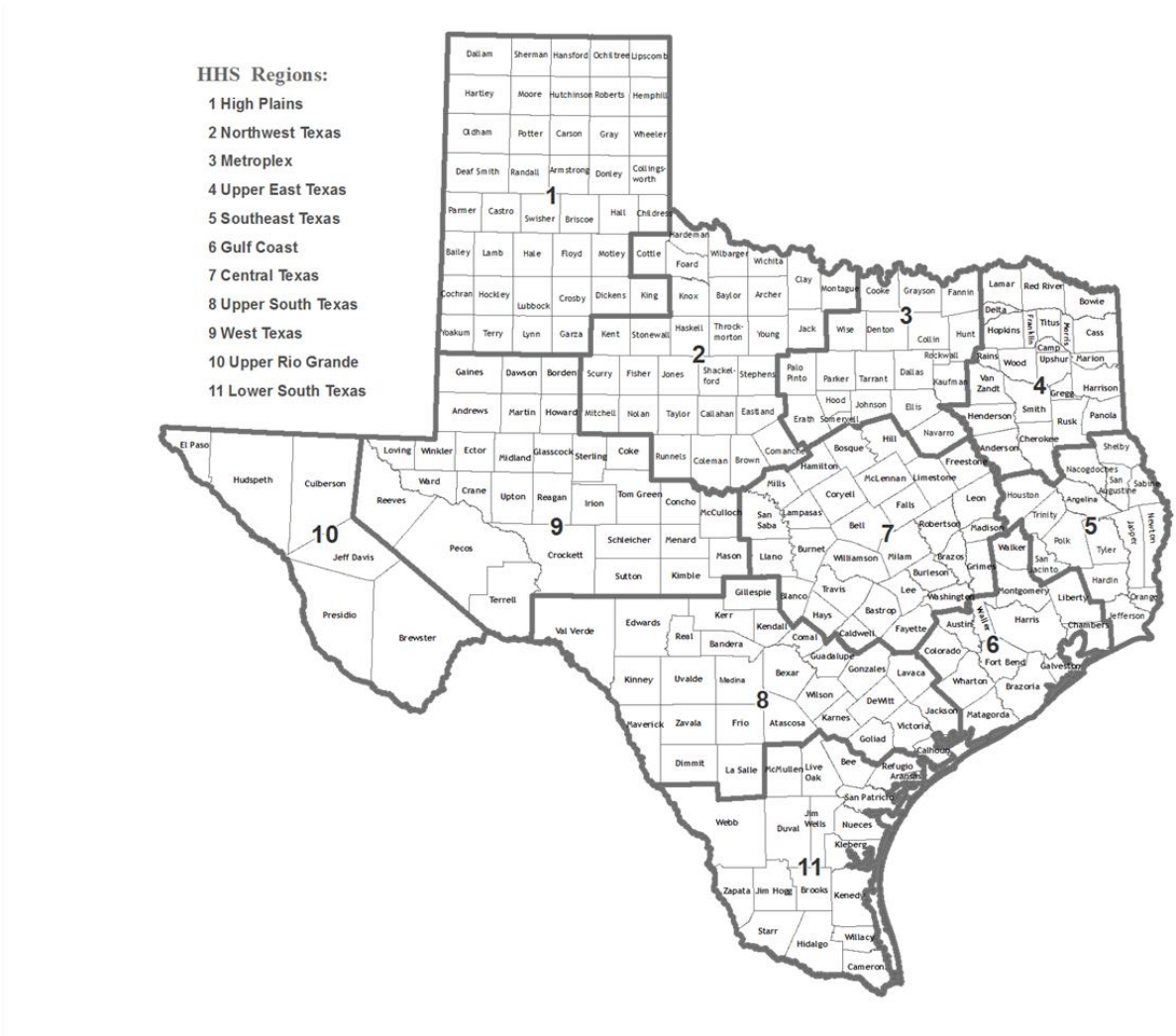
Map of the Health and Human Services System Regions



Source: Health and Human Services System - Strategic Decision Support.

Schedule A: Health and Human Services System Budget Structure

The budget structure for the Health and Human Services System agencies will be submitted once approved. An extension was previously requested and approved.

Schedule B: Health and Human Services System List of Measure Definitions

The performance measure definitions for the Health and Human Services System agencies will be submitted once approved. An extension was previously requested and approved.

Schedule C: Health and Human Services System Historically Underutilized Businesses Plan

The Health and Human Services (HHS) System administers programs to encourage participation by historically underutilized businesses (HUBs) in all contracting and subcontracting by HHS agencies. The System's HUB Programs are designed to enhance the ability of HUBs to compete for HHS System contracts, increase agencies' awareness of such businesses, ensure meaningful HUB participation in the procurement process, and assist HHS System agencies in achieving its HUB goals.

Each state agency is required to include in its strategic plan a HUB plan. The section below describes in its entirety a coordinated HUB plan that covers the HHS System's HUB programs as a whole.

Goal

The goal of the HHS System HUB Plan is to promote fair and competitive business opportunities that maximize the inclusion of minority-owned businesses and women-owned businesses that are certified HUBs in the procurement and contracting activities of HHS System agencies.

Objective

The HHS System strives to meet or exceed the Statewide Annual HUB Utilization Goals and/or agency-specific goals that are identified each fiscal year (FY) in the procurement categories related to the HHS System's current strategies and programs.

Outcome Measures

In accordance with Section 2161(d)(5) of the Texas Government Code and the State's Disparity Study, state agencies are required to establish their own HUB goals based on scheduled fiscal year expenditures and the availability of HUBs in each procurement category.

In procuring goods and services through contracts, the HHS System, as well as each of its individual agencies, will make a good faith effort to meet or exceed the statewide goals, as described in Table C.1, and/or agency-specific goals for HUB participation for the contracts that the agency expects to award in a fiscal year.

Table C.1
Statewide HUB Goals by Procurement Categories, Fiscal Year 2015

PROCUREMENT CATEGORIES	UTILIZATION GOALS
Heavy Construction	11.20%
Building Construction	21.10%
Special Trade Construction	32.90%
Professional Services Contracts	23.70%
Other Services Contracts	26.00%
Commodity Contracts	21.10%

Table C.1: Data from FY 2015 Statewide HUB Report, Texas Comptroller of Public Accounts.

The HHS System will collectively use the following outcome measure to gauge progress:

- Total expenditures and the percentage of purchases awarded directly and indirectly through subcontracts to HUBs under the procurement categories.

Each HHS System Agency may track additional outcome measures.

HHS System Strategies

When feasible, the HHS System will consider setting higher goals for its contract opportunities. Factors to determine feasibility will include:

- HUB availability,
- Current HUB usage,
- Geographical location of the project,
- Contractual scope of work,
- Size of the contract, or
- Other relevant factors as identified.

The HHS System agencies will also maintain and implement policies and procedures, in accordance with the HUB rules, to guide the agencies in increasing the use of HUBs by contracting directly and/or indirectly by subcontracting.

The HHS agencies employ several additional strategies, such as:

- Tracking the number of contracts awarded to certified HUBs as a result of HHSC outreach efforts;

- Obtaining assurances that contractors will make a good-faith effort to subcontract with HUBs identified in their subcontracting plans and maintain the commitment throughout the contract;
- Using available HUB directories, the Internet, minority or women trade organizations or development centers to solicit bids;
- Maintaining a HUB Office, including a full-time HUB Coordinator and two HUB Administrators at the HHSC headquarters for effective coordination; and/or
- Developing and implementing a HUB Governance Plan and providing updates to the Executive Commissioner and Commissioners on Enterprise HUB Program activities, related initiatives and projects.

Output Measures

The HHS System will collectively use and individually track the following output measures to gauge progress:

- The total number of bids received from HUBs,
- The total number of contracts awarded to HUBs,
- The total amount of HUB subcontracting expenditures,
- The total amount of HUB Procurement Card expenditures,
- The total number of mentor-protégé agreements,
- The total number of HUBs awarded a contract as a direct result of HHSC outreach effort, and
- The total number of HUBs provided assistance in becoming HUB-certified.

Additional output measures which may be used by specific HHS System agencies include:

- Total number of external outreach initiatives such as HUB forums attended and sponsored, and
- Total number of internal outreach initiatives such as agency HUB vendor presentations (Internal HUB Forums) and individual vendor meetings.

HUB External Assessment

According to the Comptroller of Public Accounts FY 2015 Statewide Annual HUB Report, the HHS System collectively awarded 16.71 percent of all contract funds to HUBs. Table C.2 specifies details of the total FY 2015 expenditures for each HHS agency and total spending with HUBs directly and indirectly through subcontracting.

Table C.2
HHS System Expenditures with Historically Underutilized Businesses, by Agency, Fiscal Year 2015

Agency	Total Expenditures	Total Spent with All Certified HUBs	Percent
HHSC	$873,538,011	$157,532,367	18.03%
DADS	$154,035,375	$19,080,083	12.39%
DARS	$19,701,582	$3,542,512	17.98%
DFPS	$60,582,144	$16,145,009	26.65%
DSHS	$381,973,296	$52,639,453	13.78%
Total	$1,489,830,408	$248,939,424	16.71%

Table C.2: Data from FY 2015 Statewide Annual HUB Report, Texas Comptroller of Public Accounts.

The HHS System agencies made a number of internal improvements to help meet statewide and/or agency-specific HUB goals. HHS System agencies initiated an aggressive outreach effort to educate HUBs and minority businesses about the procurement process. In addition, the HHS System agencies developed and implemented a HHS HUB Governance Plan to assist with the continuous implementation, coordination, oversight, and management of the HHS agency's HUB Program initiatives in accordance with the HUB statute, rules, and/or policies throughout the HHS System.

Other areas of progress include:

- Promoting HUB usage within agencies' procurement card programs;
- Maintaining the signed Memorandum of Cooperation between HHSC and two entities: the Texas Association of African-American Chambers of Commerce and the Texas Association of Mexican-American Chambers of Commerce;
- Contracting directly with the Chambers of Commerce to provide access to minority firms and, when applicable, to assist with HUB certification and contracting opportunities;
- Conducting post-award meetings with contractors to discuss the requirements related to the HUB Subcontracting Plan and monthly reporting;
- Advertising HHSC contract opportunities on the Electronic State Business Daily (ESBD) and while attending external outreach events; and
- Developing an HHSC Business Opportunities Page on its website to maintain awareness for all HUBs.

Additional goals include:

- Enhancing outreach efforts internally and externally by promoting access, awareness, and accountability through education and training;
- Enhancing minority- and woman-owned businesses' participation in System-sponsored HUB Forums where exhibitors may participate in trade-related conferences;
- Enhancing HHS System HUB reporting capabilities;
- Expanding HHS System mentor-protégé program vision to maximize the state's resources through cooperation and assistance from other public entities and corporate businesses; and
- Promoting and increasing awareness of subcontracting opportunities in HHS System contracts, which are identified in contractors' HUB Subcontracting Plans.

Schedule D: Health and Human Services System Statewide Capital Plan

The statewide capital plan for the Health and Human Services System agencies will be submitted once approved. An extension was previously requested and approved. The material will include the information that the agencies submit to the Bond Review Board per requirement of the 2016–2017 General Appropriations Act, House Bill 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 11.03).

Schedule E: Health and Human Services System Coordinated Strategic Plan

E.1 Executive Summary

E.1.1 Introduction

The State of Texas provides health and human services to millions of Texans through the efforts of more than 58,000 state employees operating more than 200 programs from more than 1,000 locations around the state. Together, the Health and Human Services (HHS) System programs account for approximately $37.9 billion in fiscal year (FY) 2016 (all funds), approximately one-third of state spending.

Together, the HHS System agencies support and improve clients' health, safety, and well-being through many services, including: physical and behavioral health care; transition to self-sufficiency; food benefits; rehabilitation; help when disaster strikes; and protection from abuse, neglect, or exploitation. The HHS System agencies also have regulatory functions, proactively working toward health and safety in public establishments, such as restaurants, medical facilities, nursing homes, day care centers, and facilities operated or contracted by the state.

First through the enactment of House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, and most recently through the passage of several bills to implement recommendations from the Sunset Advisory Commission, the Legislature and the Governor have directed the HHS System agencies to streamline organizational structures and eliminate duplicative administrative systems, in an effort to continue to improve services and enhance efficiencies.

Transformation efforts also address further streamlining and consolidation of administrative support services, including legal, financial, contract procurement, information technology, human resources, and other administrative functions.

While the Sunset review and related legislation provided the impetus for restructuring the HHS System, this transformation will go beyond that initial direction, changing not only the system's organization, but also the way it delivers services. Transformation activities will produce an accountable, restructured system that:

- Is easier to navigate for people seeking information, benefits, or services;
- Aligns with the HHS mission, business, and statutory responsibilities;
- Breaks down operational silos to create greater program integration;
- Creates clear lines of accountability within the organization; and
- Develops clearly defined and objective performance metrics for all organizational areas.

To ensure a coordinated approach to planning and delivering health and human services, the Texas Government Code (Tex. Gov't Code) Section 531.022 requires

that the Health and Human Services Commission (HHSC) Executive Commissioner submit a strategic plan for the HHS System. Schedule E, the HHS System Coordinated Strategic Plan is submitted to fulfill that requirement. The six System goals, as well as the individual agency goals, address: the desire to create a continuum of care for families and individuals in need of health and human services; the integration of health and human services; the maximization of existing resources; the effective use of management information systems; the provision of system-wide accountability through effective monitoring mechanisms; the promotion of teamwork among health and human services agencies; the fostering of innovation at the local level; and the encouragement of full participation of fathers in programs and services relating to children. This plan is grounded in the System Vision, Mission, and Values, presented below.

At the publishing of this document in June 2016, five agencies comprise the HHS System:

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

Since DADS and DARS will be consolidated into HHSC in accordance with S.B. 200, 84th Legislature, Regular Session, 2015, this Plan reflects the new structure with three agencies.

In the planning period of 2017–2021, there may be greater demand for services from increasing numbers of individuals and families, as discussed in Part E.2 and throughout the Plan. Part E.3 highlights transformation of the HHS System in accordance with legislative direction based on Sunset recommendations. Part E.4 describes significant coordination initiatives.

E.1.2 Health and Human Services System Vision

Making a difference in the lives of the people we serve.

E.1.3 Health and Human Services System Mission

Improving the health, safety, and well-being of Texans through good stewardship of public resources.

E.1.4 Health and Human Services System Values

- **Accountability:** We operate in a manner that reflects honesty, integrity and reliability.
- **Collaboration:** We work with clients, stakeholders, public and private partners, elected officials, and our employees to make informed decisions and achieve excellence in service design and delivery.
- **Client-Focused:** We exist because people have needs, and we respect each and every person.
- **Independence:** Our services and supports allow clients to reach their full potential.
- **Stewardship:** We are focused on the appropriate use of resources entrusted to our care and use them efficiently, effectively, and in a manner that builds public trust.
- **Transparency:** We build confidence in our operations by being open, inclusive and holding ourselves accountable.
- **Diversity:** We offer programs and services that value and respect the diversity of the State of Texas.

E.1.5 Health and Human Services System Goals

HHS System Goal 1: Improve the delivery of health and human services through a transformed system that is easier to navigate for people seeking information, benefits, or services.

HHSC Strategic Goals

Goal 1: Provide efficient, effective medical and behavioral health services.
Goal 4: Provide efficient, effective services for individuals in 24-hour state facilities.

DSHS Strategic Goals

Goal 1: Improve health through prevention and population-health strategies.
Goal 2: Enhance public health response to disasters and disease outbreaks.
Goal 4: Expand the effective use of health information.

HHS System Goal 2: Create opportunities that lead to increased self-sufficiency and independence.

HHSC Strategic Goals

Goal 2: Provide efficient, effective social services.
Goal 3: Coordinate with diverse communities and organizations to strengthen and to support the provision of a spectrum of medical, health, and social services.

HHS System Goal 3: Improve and protect the health, safety, and well-being of Texans.

HHSC Strategic Goals

Goal 5: Promote consumer health and safety through focused regulatory and licensing activities.

DFPS Strategic Goals

Goal 1: Protect children, families, older adults, and people with disabilities from abuse, neglect, and exploitation through quality investigations.
Goal 2: Work with community partners to strengthen family systems and improve outcomes through effective service delivery.
Goal 3: Work with Texas communities to provide services that prevent child abuse and neglect and promote positive child, youth, and family outcomes based on analysis of community risk and protective factors as well as local needs assessments.
Goal 4: Provide 24/7 intake operations to capture vital information needed to respond to vulnerable Texans.

DSHS Strategic Goals

Goal 3: Reduce health problems through public health consumer protection.

HHS System Goal 4: Implement an efficient and effective consolidated administrative support structure for the HHS System.

HHSC Strategic Goals

Goal 7: Improve the effectiveness and efficiency of system oversight and program support.

HHS System Goal 5: Make informed decisions through collaboration with external partners.

The HHS System works with independent boards, advisory committees, and interagency task forces that take public comment at posted meetings and work with stakeholders to improve policy and outcomes.

There are more than 50 advisory committees across the HHS system, consisting of public members who advise on a wide range of topics and program areas including Medicaid and social services programs, managed care service delivery, health care quality initiatives, services to persons with disabilities, behavioral health, regulatory matters, public health, and many more. Advisory committees are comprised of

public members who represent consumers, service providers, and others affected by or interested in HHS programs, and they reside in communities across the state. With their individual knowledge and experience, advisory committee members assist HHS program staff in making informed policy recommendations and decisions.

A cross-agency workgroup reviewed the ongoing needs of all advisory committees, with the goal of achieving a more effective way for stakeholders to provide meaningful input on system programs. The workgroup developed criteria to evaluate the committees. Based on the evaluation, the workgroup prepared a summary of findings to post for stakeholder and public input. In September 2015, stakeholders provided feedback that was gathered, evaluated, and presented to the Executive Commissioner, whose final decisions were posted to the Texas Register on October 30, 2015. Staff drafted the necessary rules, gathered additional feedback from stakeholders, and presented them to each agency's advisory council for approval. These rules become effective July 1, 2016.

HHS System Goal 6: Ensure the integrity of health and human service providers.

HHSC Strategic Goals

Goal 6: Ensure the integrity of health and human services programs through the Inspector General.

E.2 Trends in the Operating Environment

E.2.1 Statewide Demographic, Economic, and Health Trends

Key demographic trends and changing economic conditions affect the complex environment in which the HHS System agencies operate.

Below is a list of race/ethnic terms, with their respective definitions, as used in the Plan:

- African American—Black, non-Hispanic;
- Anglo—White, non-Hispanic;
- Hispanic—Cultural identification, can include persons of any race; and
- Other—All other non-Hispanic population groups combined, including Chinese, Vietnamese, Native American, Eskimo, and others.

Demographic Trends

Demographic trends that could impact HHS System programs include changes in the size, composition, and geographical distribution of the population.

Population Growth

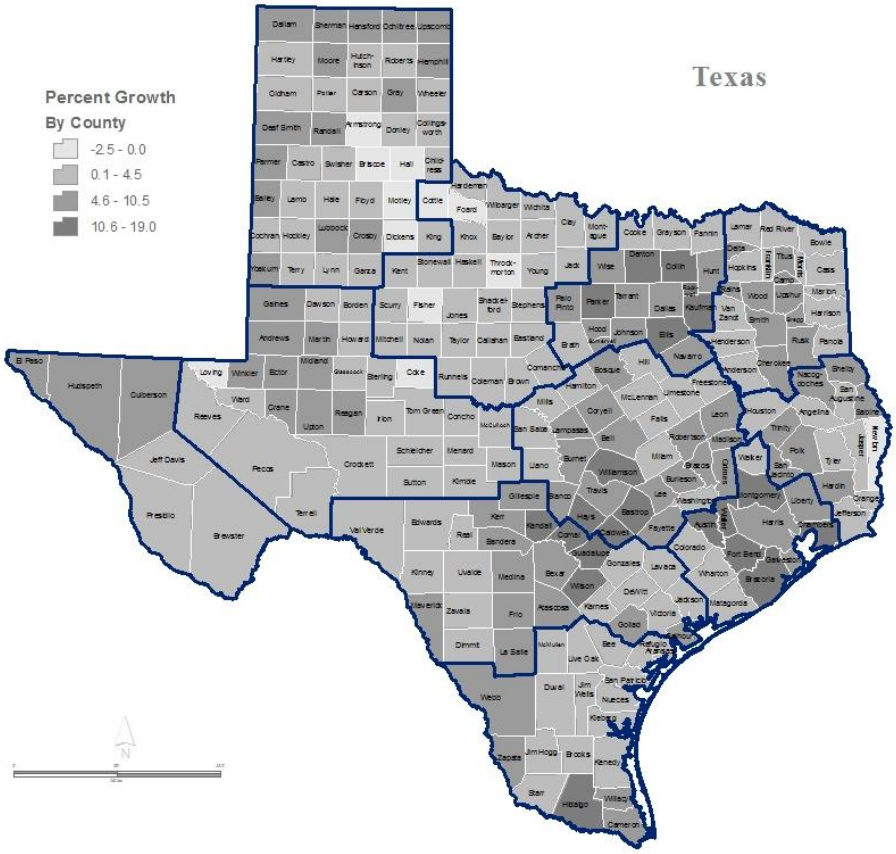
Since becoming a state in 1845, Texas has consistently experienced some of the highest population growth in the nation. According to the 2010 Census of Population, Texas is the second-most populous state, with 25.1 million residents,[1] and has continued to experience strong population growth.

The United States (U.S.) Census Bureau estimates that between 2010 and 2015 the state's population grew at a significantly higher rate compared to the U.S. as a whole, at 9.2 percent versus 4.1 percent.[2] Both natural increase (the amount by which the number of births exceeds the number of deaths) and positive net migration (the amount by which in-migrants outnumber out-migrants) have contributed strongly to recent population growth. The Census Bureau estimates that positive net migration, or in-migrants, accounted for 52 percent of the total population growth in the state during this period.[3]

The state's population is projected to increase by 3.7 million or 15 percent between 2010 and 2017. The population is projected to reach to 28.8 million in 2017, when it will comprise close to 9 percent of the total U.S. population. The State Data Center (SDC) projects that between 2017 and 2021 the population will grow by another 2.4 million or 8 percent, reaching 31 million in 2021.[4]

[1] U.S. Census Bureau. 2010 Census, Summary File 1.
[2] U.S. Census Bureau. Population Division, National and State Population Estimates, April 2010-July 2015.
[3] Ibid.
[4] The population projections for Texas cited throughout this Plan are derived from the SDC's 2000–2010 Migration Growth Scenario, which uses the 2010 Census counts and 2000-2010 migration and natural increase trends for producing population projections.

Figure E.1: Percent Population Growth by Texas County, 2017–2021



Sources: SDC, Population Projections for Texas According to the 2000–2010 Migration Scenario; HHSC, Strategic Decision Support. March 2016.

Most of the population growth is projected to occur in and around the major metropolitan regions of the state, such as Houston, Dallas-Fort Worth, San Antonio, Austin, and McAllen.

Aging of the Population

Key projected long-term trends are important. The age composition of the Texas population will change between now and the year 2050. Much of the change will be associated with the aging of the baby boom generation. The oldest of the baby boomers, persons born between 1946 and 1964, will turn 71 in the year 2017. That year, the population age 65 and older will make up 12 percent of the total population. The percent share of the population age 65 and older is projected to increase during the foreseeable future. With continued advances in medicine and health care, those who reach age 65 will have a greater chance of living to age 85 and beyond.

Between 2017 and 2050, the percent share of the population age 65 and older will increase. In 2050, older females will continue to outnumber older males, particularly among those aged 85 and older.

The population age 65 and older is projected to grow from 3.5 million in 2017 to 9.4 million in 2050. This group's share of the total population is projected to increase from 12 percent in 2017 to 17 percent in 2050. The population age 85 and older is projected to quadruple during the 2017–2050 period, growing from 371,000 in 2017 to approximately 1.6 million in 2050.

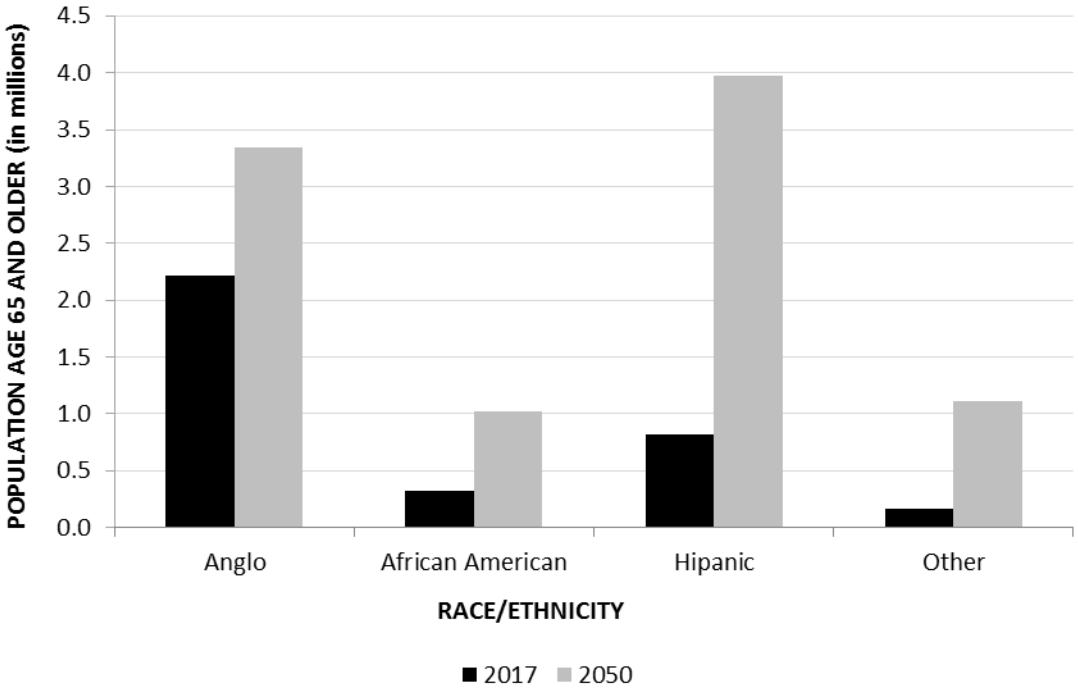
The old-age dependency ratio will also be impacted by changes in the age composition of the population. This ratio represents the number of people age 65 and older per 100 working-age people (ages 18–64). Higher values for this measure suggest a potential for more economic and other dependency of older adults on younger adults. The old-age dependency ratio for Texas is projected to increase from 20 to 29 between the years 2017 and 2050. This could mean that a greater proportion of the income and resources of younger working adults might be needed to provide income support and other forms of assistance to older retired adults who cannot work any longer due to health-related limitations or permanent disabilities.

While the population age 65 and older is projected to grow across all race/ethnic groups, the growth will be more noticeable in the non-Anglo groups. Between 2017 and 2050, the following growth rates are projected in the population age 65 and older according to race/ethnicity:

- Anglos—51 percent,
- African Americans—219 percent,
- Hispanics—390 percent, and
- All other groups (combined)—578 percent.

Figure E.2 compares the populations age 65 and older in 2017 and 2050 according to race/ethnicity. The Anglo population is projected to grow from 2.2 million to 3.3 million; the African-American population is projected to grow from 319,000 to 1 million; and the Hispanic population is projected to grow from 811,000 to 4 million. For all other groups combined, the age 65 and older population is projected to grow from 164,000 to 1.1 million.

Figure E.2: Texas Population Age 65 and Older by Race/Ethnicity, 2017 and 2050



Sources: SDC, Population Projections for Texas According to the 2000–2010 Migration Scenario; HHSC, Strategic Decision Support. March 2016.

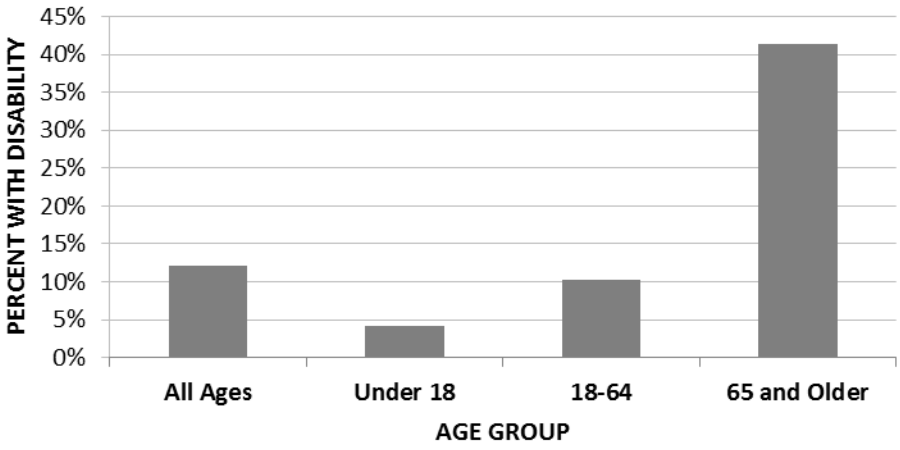
Prevalence of Disability

The gradual aging of the population will likely result in an increase in the number of people living with a disability and/or other chronic health condition. The presence of these conditions can cause difficulties in performing basic activities of daily living, such as working, bathing, dressing, cooking, and driving. People with one or more disabilities, especially those with a severe disability, are more likely to need and to use health and human services, which means that the anticipated growth trend for this population could result in a greater demand for many of the services offered by HHS System agencies.

Results from the U.S. Census Bureau's 2010–2014 American Community Survey (ACS) for Texas show that, on a yearly average basis, 3.1 million or 12 percent of Texans lived with a disability. The percentage living with a disability was higher among adults age 65 and older. During that period, 10.3 percent of adults age 18–64 and 41.4 percent of adults age 65 and older had a disability.

Figure E.3 illustrates the percent of the population with a disability according to age group.

Figure E.3: Percent of Texans with a Disability During the 2010–2014 Period, by Age Group



Source: U.S. Census Bureau, 2010–2014 ACS for Texas; HHSC, Strategic Decision Support, March 2016.

Race/Ethnic Composition of the Population

Texas is becoming more racially and ethnically diverse over time. While the Anglo population has been the largest group for decades, its proportion is changing as the non-Anglo populations are experiencing higher growth rates than the Anglo population in recent years.

According to the most recent Census, in 2010 Anglos accounted for 45 percent of the population and Hispanics for 38 percent. It is projected that the size of the Anglo and Hispanic populations will be approximately the same in 2017, when each of these groups will account for 41 percent of the total population. African Americans will account for 11 percent, and all the other groups, combined, will account for the remaining 7 percent.

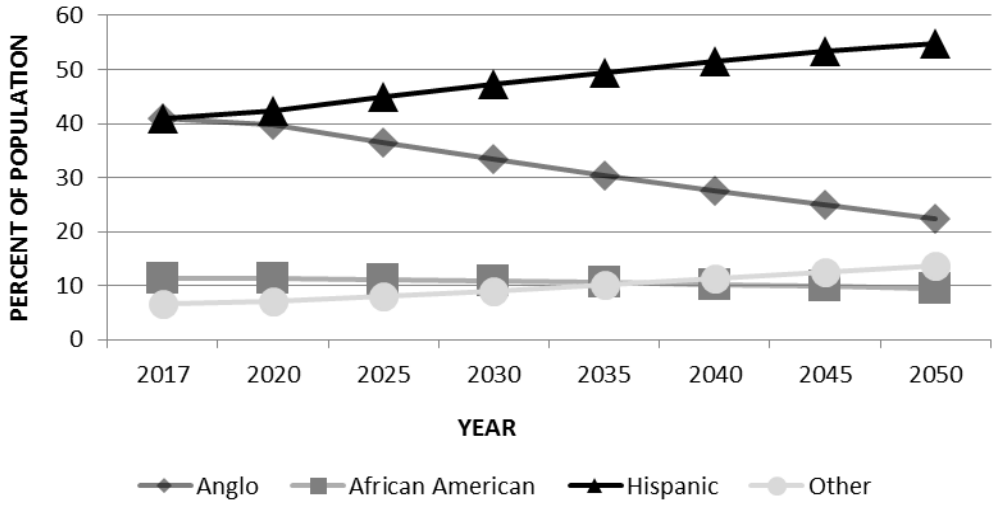
The SDC projects the following growth trends between 2017 and 2021.

- The Anglo population is projected to grow from 11.8 to 12.0 million, with a growth rate of 1 percent.
- The African-American population is projected to grow from 3.3 to 3.5 million, with a growth rate of 7 percent.
- The Hispanic population is projected to grow from 11.8 to 13.4 million, with a growth rate of 13 percent.
- The population of all the other population groups, combined, is projected to grow from 1.9 to 2.3 million, with a growth rate of 19 percent.

Over the long term, Hispanics are projected to become the largest ethnic group. They will account for 55 percent of the total population in 2050, while Anglos will account for 22 percent.

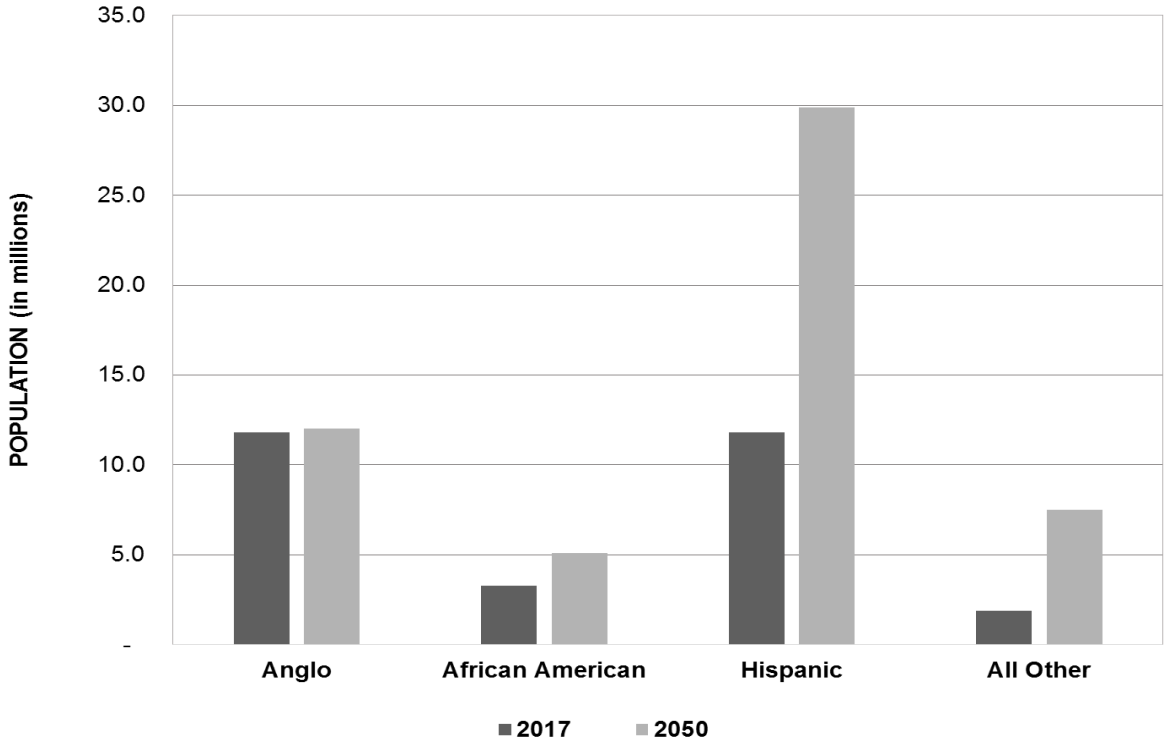
Figures E.4 and E.5 illustrate some of the projected changes in population size and population composition by race/ethnicity during the 2017-2050 period.

Figure E.4: Percent of Population by Race/Ethnicity, 2017–2050



Sources: SDC, Population Projections for Texas According to the 2000-2010 Migration Scenario; HHSC, Strategic Decision Support. March 2016.

Figure E.5: Projected Population by Race/Ethnicity in 2017 and 2050

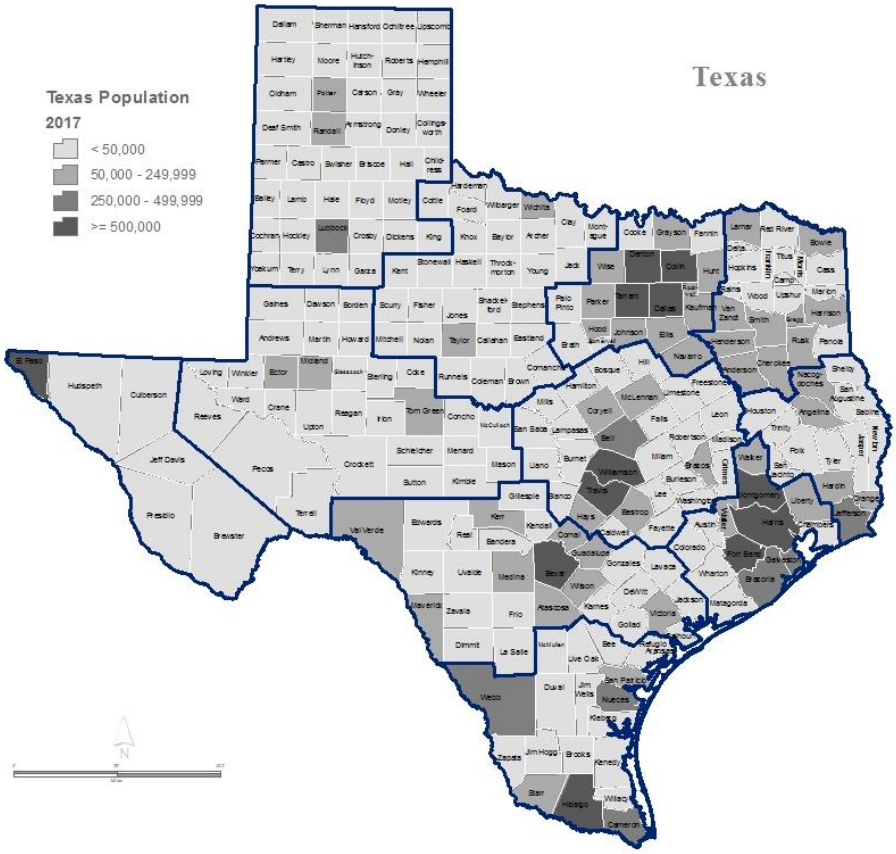


Sources: SDC, Population Projections for Texas According to the 2000-2010 Migration Scenario; HHSC, Strategic Decision Support. March 2016.

Urban and Rural Population Trends

The vast majority of the Texas population resides in counties that are part of a metropolitan area. The map in Figure E.6 depicts the projected total population in 2017 by county. The largest population concentrations will be found in and around the major metropolitan areas of the state, such as Houston, Dallas-Fort Worth, San Antonio, Austin, El Paso and McAllen. The counties with the smallest populations will be mostly found in the vast geographical regions of West, Central Northwest, and Northwest Texas.

Figure E.6: Total Population By County, 2017



Sources: SDC, Population Projections for Texas According to the 2000-2010 Migration Scenario; HHSC, Strategic Decision Support. March 2016.

According to the 2010 Census of Population, 3 million or 12 percent of Texans resided in non-metropolitan (rural) counties. Although these residents account for a relatively small fraction of the state's total population, the total population for those counties, when combined, exceeds the total population of many states. Residents of rural counties tend to experience challenges for the delivery of health and human services:

- Limited access to affordable health care,
- Limited number of trained health professionals,
- Increased need for geriatric services,
- Prolonged response times for emergency services,
- Limited job opportunities and other incentives for youth to stay in the community,
- Limited transportation options, and
- Limited economic development and fiscal resources.

Economic Forecast

The relative strength and/or weakness of the economy can impact the demand for health and human services and the government's ability to obtain needed revenues to fund those services and other priorities.

The State's economy is defined by all activities and institutions associated with the production, exchange, and consumption of goods and services. In 2015, Texas had the second-largest state economy in the U.S.,[5] accounting for 9 percent of the national economic output. Factors such as available natural resources, human and financial capital, technology, and laws and regulations impact economic activity and outcomes.

According to the U.S. Bureau of Economic Analysis,[6] in 2015, Texas' gross state product, an indicator of the size of the state's economy, was $1.64 trillion. This is the total monetary value of goods and services produced across all industries within the state during that year.

Additional analysis[7] reveals that the top six economic sectors, based on percent contribution to, were:

- Manufacturing—15 percent,
- Finance and insurance—14 percent,
- Professional and business services—11 percent,
- Government (including military)—10 percent, and
- Real estate and Mining (including oil and gas)—9 percent each.

If the favorable trends described below continue, they would help maintain the current economic expansion.[8]

- Texas' overall employment picture is encouraging. In December 2015, the seasonally adjusted unemployment rate in the state was 4.7 percent, compared to 5.0 percent for the U.S.
- The average monthly unemployment rate in 2015, 4.5 percent, was the lowest one since 2007 before the start of the last recession, when the unemployment rate bottomed out at 4.3 percent.
- From December 2012 to December 2015, the population of employed Texans grew by 523,000 or 4.4 percent, on a seasonally adjusted basis. A total of 12,486,860 Texans were employed in December 2015.
- The strong U.S. dollar and low oil prices have kept the overall consumer price index at relatively low and stable levels.
- Most of the state's counties have a relatively low unemployment rate.

[5] U.S. Bureau of Economic Analysis.
http://www.bea.gov/newsreleases/regional/gdp_state/2016/pdf/qgsp0316.pdf
[6] *Ibid.*
[7] I H S Global Insight. Economic Forecasts for Texas and the U.S. February 2016.
[8] Texas Workforce Commission. Tracer2.
http://www.tracer2.com/cgi/dataanalysis/?PAGEID=94&SUBID=120

Poverty

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

The U.S. Department of Health and Human Services defines the annual federal poverty level for family incomes for 2016 for certain family sizes as follows:[9]

- $24,300 for a family of four,
- $20,160 for a family of three,
- $16,020 for a family of two, and
- $11,880 for one-person households.

In 2014 approximately 4.5 million, or 17.2 percent of Texans, lived in households with income below the poverty level. The U.S. Census Bureau does not project future poverty population trends; however, if the percentage of households with income below the poverty level were to stay the same as in 2014 during the foreseeable future, the size of the Texas poverty population could potentially reach 5.0 million in 2017 and 5.4 million in 2021.

Health Trends

Health Risk Factors

In 2013, the most recent year for which death data is available, chronic diseases accounted for a majority of the leading causes of death in the U.S. and in Texas. Chronic diseases are generally characterized by a long period of development, a prolonged course of illness, non-contagious origin, functional impairment or disability, multiple risk factors, and low curability. Table E.3 provides information relating to the ten leading causes of death in Texas in 2013.

[9] U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation: Federal Register / Vol. 81, No. 15 / Monday, January 25, 2016 / Notices.

Table E.3: Leading Causes of Texas Deaths, 2013[10]

Ranking	Disease	Percentage
1	Diseases of the Heart	22.5%
2	Malignant Neoplasms (Cancer)	21.5%
3	Chronic Lower Respiratory Diseases	5.5%
4	Accidents (Unintentional Injuries)	5.2%
5	Cerebrovascular Diseases	5.1%
6	Alzheimer's Disease	3.0%
7	Diabetes	2.9%
8	Septicemia	2.2%
9	Nephritis, Nephrotic Syndrome, and Nephrosis (Kidney Diseases)	2.1%
10	Chronic Liver Disease and Cirrhosis	1.9%
All Other Causes		28.1%
Total Deaths in 2013		**100.0%**

Source: DSHS, 2016.

Four of the top five leading causes of death in Texas in 2013 have several risk factors in common. Cardiovascular disease includes heart disease, stroke, and congestive heart failure. The risk factors for cardiovascular disease include hypertension, tobacco use, high cholesterol levels, physical inactivity, poor nutrition, obesity, and environmental air quality factors, such as exposure to particulate air pollution and second-hand tobacco smoke. Risk factors associated with cancer include tobacco use, poor nutrition, physical inactivity, and obesity. Diabetes can lead to disabling health conditions, such as heart disease, stroke, kidney failure, leg and foot amputations, and blindness. Risk factors for diabetes include poor nutrition, physical inactivity, and obesity.

Understanding certain risk factors can help in developing strategies to reduce the impact of preventable or treatable chronic conditions. These risk factors are tracked

[10] DSHS, "Vital Statistics Annual Report: Leading Causes of Death in Texas - 2013." (http://www.dshs.state.tx.us/chs/vstat/vs13/t16.aspx).

at the state and national levels to understand the health status of populations and to inform policymaking. Some of these risk factors include:

- Physical inactivity,
- Obesity,
- Tobacco use,
- Substance use,
- Risky sexual behavior,
- Mental illness,
- Injuries and violence,
- Lack of immunizations,
- Environmental dangers, and
- Lack of access to health care.

Mental Health

Mental illness is a leading cause of disability in the U.S.[11] It is estimated that 17.8 percent of the adult U.S. population has a mental health disorder during the course of a year.[12] In Texas, the 2014 estimated number of adults with serious and persistent mental illness was 515,875.[13] Approximately 20 percent of U.S. children and adolescents have some type of mental disorder.[14] 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 7 percent of children ages 9 to 17. In 2014, the estimated number of children with SED in Texas was 248,525.[15]

Behavioral Risk Factors

The leading causes of death can be linked to one or more significant behavioral risk factors. Three risk behaviors that are major contributors to cardiovascular disease and cancer include tobacco use, poor nutrition, and physical inactivity. The Texas Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS) take an in-depth look at behavioral risk factor prevalence in Texas

[11] U.S. Burden of Disease Collaborators. The state of U.S. health, 1990-2010: burden of diseases, injuries, and risk factors. JAMA, 310(6): 591-608, 2013.
[12] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (November 19, 2013). The NSDUH Report: Revised Estimates of Mental Illness from the National Survey on Drug Use and Health. Rockville, MD. (http://www.samhsa.gov/data/sites/default/files/NSDUH148/NSDUH148/sr148-mental-illness-estimates.pdf)
[13] CMHS, SAMHSA, HHS (1999) Estimation Methodology for Adults with Serious Mental Illness (SMI). Federal Register v 64.
[14] National Institute of Mental Health. Any disorder among children. http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml. Accessed March 4 2016.
[15] CMHS, SAMHSA, HHS (1998) Children with Serious Emotional Disturbance: Estimation Methodology. Federal Register v63 n137, pp. 38661-38665.

and are important tools for decision-making throughout DSHS and the public health community.[16]

Substance Use

Substance use is another underlying behavior in a wide range of health problems. Certain statistics characterize alcohol abuse or use in Texas.

- In 2016, the economic impact of alcohol abuse was estimated to be $25.6 billion, which includes health care expenditures, lost productivity, motor vehicle accidents, crime, and other costs.[17]
- Of the 3,538 motor vehicle fatalities in 2014, 1,446 (41 percent) were alcohol-related.[18]
- In 2014, 51 percent of secondary and middle school students reported they had ever used alcohol, while almost 30 percent reported past-month alcohol use.[19]

Drug use is costly to the individual, the family, and the state.

- In 2016, the economic impact of illegal drug use in Texas was roughly estimated to be $14.6 billion.[20]
- In 2014, 51 percent of secondary and middle school students reported they had ever used an illicit drug, while 14 percent reported past-month drug use.[21]
- In fiscal year 2015, approximately 11 percent of all DSHS-funded substance abuse treatment clients participated in a co-occurring psychiatric and substance use disorders program.[22]

Tobacco Use

Tobacco use is the single largest cause of preventable, premature death, and disease in Texas. Tobacco use is a primary contributor to lung disease, heart disease, and diseases of the mouth, breast, pharynx, esophagus, pancreas, kidney, bladder, and uterine cervix. Tobacco products are associated with the deaths of more than 400,000 people in the U.S. every year. In Texas, 24,200 adults die annually from smoking-related causes. Additionally, for every person who dies from a tobacco-related cause, an additional 20 suffer from tobacco-related diseases.

[16] DSHS, BRFSS. (http://www.dshs.state.tx.us/chs/brfss/default.shtm).
[17] DSHS, Division of Mental Health and Substance Abuse Services, Office of Decision Support, January 2016.
[18] National Highway Traffic Safety Administration's Fatality Analysis Reporting System. Alcohol-Impaired Driving Fatalities: Texas, US and Best State. (http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/48_TX/2014/48_TX_2014.htm)
[19] DSHS. Texas School Survey of Drug and Alcohol Use: 2014. http://www.texasschoolsurvey.org/Documents/tss2014_state7.pdf Accessed March 4 2016.
[20] DSHS, Division of Mental Health and Substance Abuse Services, Office of Decision Support, January 2016.
[21] DSHS. Texas School Survey of Drug and Alcohol Use: 2014. http://www.texasschoolsurvey.org/Documents/tss2014_state7.pdf Accessed March 4 2016.
[22] DSHS, Clinical Management for Behavioral Health Services Data.

Tobacco use and its related health consequences take a high toll on lower-income and less-educated populations who disproportionately use tobacco products and who have less access to health care due to a lack of insurance. According to the findings from the 2014 Texas BRFSS, individuals with less than a high school education have an 18.0 percent prevalence for smoking and a 52.2 percent prevalence for lacking health insurance. This study found that those who make less than $25,000 per year have an 18.6 percent prevalence rate for smoking and a 46.5 percent prevalence for lacking health insurance. This compares to a statewide average of a 14.5 percent prevalence for smoking and a 24.9 percent prevalence for lacking health insurance.

In addition to causing disparate harm to individuals with a lower socio-economic status, tobacco takes a profound toll on persons who also are addicted to alcohol and/or illicit drugs, and those who experience mental illness. According to the National Association of State Mental Health Program Directors, 75 percent of individuals with either addictions or mental illness smoke cigarettes, compared to 22 percent of the general population. Additionally, nearly half of all cigarettes consumed in the U.S. are by individuals with a psychiatric disorder. On average, persons with serious mental illness die 25 years younger than the general population—largely from conditions caused or worsened by smoking.

Nutrition and Physical Activity

Poor diet and physical inactivity often lead to being overweight and obese, the second leading cause of preventable mortality and morbidity in the U.S. These factors account for more than 100,000 deaths annually, and they impose economic costs that are second only to smoking.

- The prevalence rate of adults who are either overweight or obese is rising in Texas. In 2014, 67.8 percent of Texas adults were overweight or obese.[23]
- In 2014, 31.9 percent of adult Texans were obese, compared to 28.9 percent nationwide.
- In 2013, 15.7 percent of high school students were obese (at or above the 95th percentile for body mass index, by age and sex).
- Male students were more likely than female students to be obese (19.4 percent vs. 11.8 percent).
- Hispanic students were more likely than Anglos to be obese (19.0 percent vs. 12.1 percent).

Regular physical activity, even in moderate amounts, has been shown to produce significant health benefits. Despite this fact, the BRFSS and YRBS showed that many adults in Texas reported little or no exercise.

- In Texas, 27.6 percent of adults reported no leisure-time physical activity in the past month, compared to 23.7 percent of adults nationwide in 2014.

[23] DSHS, Center for Health Statistics, 2014 Texas BRFSS.

- Hispanics and African Americans in Texas had higher rates of no leisure-time physical activity, 34.8 percent and 30.6 percent respectively, compared to 21.9 percent of Anglos.
- In 2013, 57.9 percent of adult Texans did not meet aerobic recommendations according to the 2008 Physical Activity Guidelines for Americans.
- According to the 2013 Texas YRBS, 32.9 percent of Texas adolescents in grades 9–12 watched television for 3 or more hours per day on an average school day.
- African American adolescents had the highest rate of 3 or more hours of television time per day at 49.1 percent, followed by Hispanics at 35.2 percent, and Anglos at 25.5 percent.
- In 2013, more than one out of 3 Texas high school students (38.0 percent) played video games or computer games, or used a computer for something that was not for schoolwork, for 3 or more hours per day on an average day.

Maternal and Child Health

Improving the health and well-being of mothers, infants, and children in Texas is vitally important, because their well-being determines the health of the upcoming generation. In addition, the current health status of mothers and children can help to predict future health issues for families, communities, the health care system, and public health policymakers. Racial disparities have an impact on maternal and child health.

Maternal and Women's Health

- In 2013, less than two-thirds of Texas women of childbearing age reported having a routine checkup in the past year.[24]
- The rate of women giving birth who received adequate prenatal care has plateaued between 2011 and 2013, with only 64.5 percent of women having a prenatal visit in the first trimester of pregnancy.[25]
- Approximately 61 percent of women in Texas were overweight or obese in 2013.[26] Rates of pre-pregnancy obesity have increased more than 22 percent for African-American and Hispanic women from 2005 to 2013, from 25.7 to 31.4 percent among African-American women, and from 21.2 to 26.8 percent among Hispanic women.[27]

Perinatal and Infant Health

- While Texas has high rates of initiation of breastfeeding, an estimated 83.3 percent in 2012, the percent of women who exclusively breastfeed is still relatively low. According to 2012 National Immunization Survey results for

[24] BRFSS data, 2013
[25] Texas birth files, DSHS Center for Health Statistics
[26] DSHS Division of Mental Health and Substance Abuse Services, Office of Decision Support, January 2016.
[27] Texas birth files, DSHS Center for Health Statistics

Texas, 43.7 percent of mothers reported exclusive breastfeeding at 3 months, and 21.3 percent of mothers reported exclusive breastfeeding at 6 months.

- The preterm birth rate in Texas was 12.3 percent in 2013, which was higher than the Healthy People 2020 target and the national average (both 11.4 percent). The rate of preterm births has decreased among all race/ethnic groups from 2004 to 2013, especially among infants born to African-American mothers. However, African-American mothers still had the highest rate of preterm births in 2013 (16.1 percent).
- Texas' infant mortality rate has been lower than the national rate for the past ten years. Racial/ethnic disparities in infant mortality have persisted; the infant mortality rate for African-American mothers (11.9 per 1,000 live births) was more than 2 times higher than the infant mortality rate for Anglo mothers (5.0 per 1,000 live births) in 2013.[28]

The Healthy Texas Babies initiative seeks to modify maternal and infant risk factors for poor birth outcomes and infant death that exist across the lifespan, with an emphasis on persistent disparities affecting specific populations in our state. DSHS also coordinates efforts to reduce maternal mortality and severe maternal morbidity. Based upon implementation of S.B. 495, 83rd Legislature, Regular Session, 2013, DSHS has established the Maternal Mortality and Morbidity Task Force and will report findings to the Legislature.

Child and Adolescent Health

- As in past years, child injury was the leading cause of death for children ages 1–14 in 2013, accounting for 35.3 percent of all deaths among boys and 23.7 percent of all deaths among girls of this age group.[29]
- Child abuse and neglect fatalities accounted for 11 percent of all non-natural deaths among children from birth through age 17 in 2014.[30]
- The suicide rate increased slightly for adolescents (ages 15–17) from 5.9 suicide deaths per 100,000 in 2008 to 6.9 suicides per 100,000 in 2012.[31]

Impact of Infectious Diseases

DSHS engages in a variety of responses to natural disasters and other public health emergencies. In recent years, the agency has not had to respond to severe storms and hurricanes, but has engaged in ongoing control and prevention activities related to emerging and re-emerging infectious diseases.

[28] Texas 2013 birth and death files, DSHS Center for Health Statistics
[29] DSHS, Texas Vital Statistics 2013 Annual Report (http://www.dshs.state.tx.us/chs/vstat/vs13/data.aspx)
[30] DFPS—Texas death certificate linked files, 2014
[31] Texas 2008-2012 death files, DSHS Center for Health Statistics

Response to Ebola Virus Disease

The first diagnosis of Ebola virus disease in North America occurred in September 2014 in Dallas, when a traveler from Liberia was admitted to a Dallas healthcare facility. Shortly following the man's death, two nurses who had provided him direct patient care were also diagnosed with Ebola virus infection. Both nurses survived their illnesses.

DSHS coordinated with the Centers for Disease Control and Prevention (CDC) and local health departments regarding travelers in their jurisdictions. DSHS also monitored travelers through regional offices for locations where there is no health department. Travelers from West Africa were monitored for fever and other symptoms for 21 days. DSHS provided epidemiological investigation support to follow up on potentially exposed individuals, laboratory testing, control orders, public information, media coordination, contamination remediation, biohazard waste management and disposal, veterinary support for an exposed pet, and disaster behavioral health support.

Using state and federal funding, DSHS has since focused on preparing for the emergence of high-consequence diseases such as Ebola, novel strains of influenza, and the MERS coronavirus. DSHS has held statewide workshops and exercises and has also worked to improve laboratory and epidemiological surveillance capacity. Additional funding and preparedness resources, including planning support, training opportunities, reference materials, and exercises, have also been shared across the state with local health departments and other health care organizations.

Foodborne Outbreaks

Texas has seen many foodborne illnesses including Cyclosporiasis and Listeriosis. These illnesses are often smaller outbreaks handled locally in communities. DSHS may be involved in larger outbreaks that cross communities or that are part of a national foodborne illness investigation.

Cyclospora

In June 2015, DSHS determined that more than 40 Cyclospora-positive lab reports had been submitted in 1 week, an exceptionally high number. Ultimately, 241 laboratory-confirmed cases of Cyclospora were reported, and 219 patient interviews completed. The Texas Rapid Response Team was activated and made possible tracebacks of foods implicated by the epidemiology investigations. The rapid, intensive work resulted in identification of cilantro from Mexico being the most probable vehicle. The U.S. Food and Drug Administration (FDA) issued an import alert detaining cilantro from Puebla, Mexico, coming into the U.S.

Listeria

In March 2015, four cases of listeriosis were identified in Kansas that had specimens with genetic fingerprints matching samples of ice cream produced in a Texas facility of a Texas-based ice cream company. The ice cream samples found to be contaminated had been tested in South Carolina as part of routine sampling activities there. The ice cream company issued a limited recall and later expanded it to their entire line of products. Investigations of other previously identified listeriosis cases resulted in an increase of the case count to 10, including 3 in Texas. Three of the case-patients, all in Kansas, died. DSHS staff worked closely with the CDC and FDA to investigate the source of the infection. Staff monitored the company to ensure that it resumed ice cream production only after thorough cleaning of the plant and implementation of practices to prevent the chance of recurrence of contamination at the plant.

Arbovirus Diseases

There is an ongoing threat of mosquito-borne diseases across Texas that includes the recurrence of West Nile virus and the emerging threats of Chikungunya, Dengue, and Zika viruses. The 2012 West Nile virus season in Texas was the most severe on record, and it provided many lessons for use in planning for and responding to future threats of arbovirus diseases. DSHS provided leadership throughout the response by maintaining situational awareness, compiling case counts, and coordinating key information with local and federal partners. DSHS completed other activities, such as conducting laboratory testing, coordinating with the Centers for Disease Control and Prevention teams to assist in outbreak analysis, providing geographic information system mapping of cases and incidence rates, developing and disseminating public outreach and education, activating vector control contracts, and providing other support for ground and aerial spraying.

In May 2015, the Pan American Health Organization issued an alert regarding the first confirmed Zika virus infection (Zika) in Brazil. On February 1, 2016, the World Health Organization declared Zika a public health emergency of international concern.

Zika is spread to people primarily through the bite of an Aedes species mosquito infected with the Zika virus. The most common symptoms of Zika are fever, rash, joint pain, and conjunctivitis (red eyes). The illness is usually mild, with symptoms lasting for several days to a week after being bitten by an infected mosquito. CDC has stated that Zika virus infection during pregnancy can cause a serious birth defect called microcephaly, as well as other severe fetal brain defects. There is also evidence that Zika is associated with cases of a paralytic condition called Guillain-Barré syndrome.

Local transmission of Zika has been reported in Mexico and many South and Central American countries. As of May 24, 2016, all cases in Texas have been travel-related, with one confirmed case of sexual transmission through a partner with

travel-related infection. Planning and communication strategies have been initiated to prepare for the growing threat of local Zika virus transmission.

Healthcare-Associated Infections

Healthcare-associated infections (HAIs) and preventable adverse events (PAEs) continue as significant causes of morbidity and mortality nationally and in Texas. In the U.S., an estimated 722,000 patients acquire HAIs annually, and as many as 75,000 of those patients die during their hospital stay. In an effort to reduce HAIs and PAEs in, the Legislature mandated HAI reporting in 2007 and PAE reporting in 2009. General hospitals and ambulatory surgical centers in Texas must report certain central line-associated bloodstream infections, catheter associated urinary tract infections, and surgical site infections. Reportable PAEs not related to infections can include events resulting in patient death or severe harm, such as a fall in a health care facility or an object left in the patient after surgery. The public can view facility level HAIs and PAEs for each of these events or procedures on the public website at www.haitexas.org.

Certain multi-drug resistant organisms—bacteria that do not respond to many antibiotics--must now be reported by any health care provider, not just hospitals and ambulatory surgical centers. Well over 1,000 such infections were reported in Texas in both 2014 and 2015, making these among the most numerous of all reportable infections in Texas.

Health Insurance Coverage

The U.S. Census Bureau's ACS gathered health insurance coverage information for 2013 and 2014. Between 2013 and 2014, the number of uninsured in Texas declined by approximately 700,000, from 5.7 million to 5 million, while the rate of people without insurance decreased from 22.1 percent to 19.1 percent. In addition, in 2014, 734,000 individuals obtained coverage through the federal marketplace. Eighty-four percent of individuals covered by plans purchased through the marketplace received federal financial subsidies.[32]

The population of people without health insurance in Texas in 2014 had the following characteristics.

- Approximately 784,000, or 16 percent, were children younger than age 18, and 4.2 million, or 84 percent, were ages 18 to 64.
- Fewer than 60,000 persons age 65 or older were uninsured because there is almost universal access to Medicare for this group.
- Approximately 3.5 million, or 69 percent, were U.S. citizens and 1.56 million, or 31 percent, were non-U.S. citizens.
- Approximately 2.7 million people without insurance were employed adults age 18 or older.

[32] U.S. DHHS: Addendum to the Health Insurance Marketplace Summary Enrollment Report for the Initial Annual Open Enrollment Period. May 1, 2014.

- Among people without insurance, there was disproportionate representation on the basis of race/ethnicity, as follows.
  - Anglos represented 43.4 percent of the total population but 24.6 percent of the uninsured.
  - Hispanics represented 38.8 percent of the total population but 60.9 percent of the uninsured.
  - African Americans represented 11.8 percent of the total population but 16.1 percent of the uninsured.

Between 2013 and 2014, there was increased use of most types of private health insurance and Medicare in Texas. There were variations according to age group in the percentages of people covered by private insurance versus Medicaid or the Children's Health Insurance Program (CHIP).

- Among all Texans, 60.6 percent had private insurance and 17.3 percent had Medicaid or CHIP.
- Among Texans younger than age 65, 61.2 percent had private insurance, and 17.7 percent had Medicaid or CHIP.
- Among Texans younger than age 18, 51 percent had private insurance, and 39.8 percent had Medicaid or CHIP.
- Among Texans ages 18 to 64, 65.7 percent had private insurance, and 8.1 percent had Medicaid or CHIP.

Compared to the U.S. as a whole, in 2014 a lower percentage of Texas children under age 18 and adults age 18 to 64 were covered by private health insurance; however, the percentages for Medicaid participation were more similar for children under age 18 and for adults age 65 or older.

E.2.2 Recent State and Federal Policy Direction

This discussion highlights the most significant recent policy direction for the Texas HHS System as a whole.

State Changes to Medicaid

Direction to Contain Medicaid Cost Growth

As Medicaid spending continues to grow, state policy makers have directed HHSC to pursue multiple efforts to contain Medicaid spending. The 2016–2017 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 50) reduces HHSC's appropriation by $373 million in general revenue based on development of new Medicaid cost containment initiatives, such as more appropriate rates for acute care therapy services, increased efficiencies in the vendor drug program, strengthened prior authorization and utilization review requirements, increased third-party recoveries, and increased activities to combat fraud, waste and abuse.

While recent efforts to contain Medicaid costs have produced positive results, the demand for Medicaid services continues to rise, increasing overall Medicaid costs to the state. HHSC will continue this focus on Medicaid cost containment efforts in the future.

Improving Medicaid Managed Care Operations

Over the last several sessions, the Legislature has directed HHSC to provide Medicaid services through managed care organizations (MCOs). S.B. 760, 84th Legislature, Regular Session, 2015, gives HHSC additional tools to adequately monitor contracts with the MCOs and to ensure that they are being held accountable for having adequate provider networks to deliver the care for which the state is paying. To implement the bill, HHSC is facilitating a stakeholder workgroup to discuss ways to strengthen Medicaid managed care provider networks, including online provider directories, provider access standards, and expedited credentialing.

State Direction for Mental Health Services

In an effort to address behavioral health service fragmentation, Article IX, Section 10.04 of the 2016–2017 General Appropriations Act (84-R) created the Statewide Behavioral Health Coordinating Council to work collectively to develop a coordinated five-year strategic plan and a coordinated expenditure plan for FY 2017. The council's work is discussed below, in section E.4.1.

Additionally, the Texas Veterans + Family Alliance, established by S.B. 55, 84th Legislature, Regular Session, 2015, provides $20 million of state funds to be matched with local and private funds for mental health support for veterans and their families. The program focuses on community collaborations addressing the mental health needs of veterans and their families that are not currently being met.

Federal Program Reauthorizations

Temporary Assistance for Needy Families

The Temporary Assistance for Needy Families (TANF) program requires federal reauthorization every five years. The program was scheduled for reauthorization in 2010, but has been reauthorized until September 30, 2016 through periodic short-term extensions. While Congress has not considered a bill for a full reauthorization of TANF, the U.S. House of Representatives and Senate have held hearings on how to improve TANF. These hearings have largely focused on supporting programs by states that are evidence-based and successfully help people out of poverty and move people from TANF to unsubsidized employment.

The President’s federal fiscal year (FFY) 2017 budget does not provide a full TANF reauthorization proposal. The budget proposal again included a proposal to repurpose funding for the TANF Contingency Fund for the Pathway to Jobs Initiative.

Children's Health Insurance Program

CHIP was reauthorized for five years through the Children's Health Insurance Program Reauthorization Act of 2009. The Affordable Care Act included a two year reauthorization of CHIP, and then the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) reauthorized CHIP again through FFY 2017.

Older Americans Act Programs

In April 2016 the President signed into law a bill reauthorizing the Older Americans Act (OAA) programs through FFY 2019. The last OAA reauthorization had been in 2006. The Title III funding formulas were updated in the reauthorization to change the "hold harmless" provision that ensured every state received no less than its FFY 2006 amount. Beginning in FFY 2017, state hold harmless amounts are reduced by no more than 1 percent from the previous fiscal year. The 2016 reauthorization makes these changes to the hold harmless provision for formulas for the following OAA programs: supportive services and centers; congregate nutrition services; home delivered nutrition services; and disease prevention and health promotion services.

E.3 Transformation of the Health and Human Services System

In 1991, there were 12 separate state agencies providing health and human services. A review determined that lack of coordination among them resulted in fragmentation, duplication, and inefficiency. H.B. 7, 72nd Legislature, First Called Session, 1991, was passed to address these problems by creating HHSC to facilitate coordinated planning and delivery of services. The original 12 agencies continued their existence and coordinated efforts with HHSC. Progress was made, yet redundancies and inefficiencies persisted.

A major consolidation came with the passage of H.B. 2292, 78th Legislature, Regular Session, 2003, which combined the 12 agencies into 5 and gave HHSC more responsibility and authority for providing guidance, coordination, and leadership for the system. HHSC was also made responsible for the centralization of most of the administrative support functions that had been provided individually by the majority of the 12 former agencies.

The consolidation of the agencies was accomplished by September 1, 2004, with the commencement of operations by DSHS and DADS. They joined HHSC, DARS, and DFPS in comprising the streamlined HHS System.

As a result of recommendations by the Sunset Advisory Commission, several bills were passed in 2015 to give the HHS System further opportunity to develop a more fully streamlined, efficient system that more effectively provides services and

benefits. Together, these bills outline a phased approach to the restructuring of programs and services among agencies.

The first phase increases opportunities for streamlining by making several changes in the locations of programs. The following programs and functions will transfer to HHSC by September 1, 2016: eight functions at DARS (Autism Program; Texas Autism Research and Resource Center; Blind Children's Vocational Discovery and Development Program; Blindness Education, Screening, and Treatment; Comprehensive Rehabilitation Services; Deaf and Hard of Hearing Services; Disability Determination Services; Early Childhood Intervention; and Independent Living Services); client services at DADS; and client services at DSHS.

Transformation efforts also address streamlining and consolidation of administrative support services, including legal, financial, contract procurement, information technology, human resources, and other administrative functions.

As a result of this transfer and the transfer of other programs to the Texas Workforce Commission, DARS will be abolished on September 1, 2016. Additionally, the Nurse Family Partnership and Texas Home Visiting programs were transferred from HHSC to DFPS on May 1, 2016, and DFPS will continue its focus on protective services and strengthen its prevention and early intervention programming.

In the second phase, DADS and DSHS regulatory programs and management of the operations of the state supported living centers and state hospitals will transfer to HHSC by September 1, 2017, and DADS will be abolished. After these transfers, DSHS will focus on its core public health functions and DFPS on child and adult protective services, including prevention and early intervention.

E.4 Coordination Initiatives

To ensure the development of a comprehensive, statewide approach to the planning of health and human services, the HHS System agencies coordinate on a variety of initiatives and projects, with each other and with agencies outside the HHS System. This section describes some of the major efforts.

E.4.1 Statewide Behavioral Health Coordination

Behavioral health services in Texas—which encompass both mental health and substance use treatment—have evolved and transformed over the past decade. Much of this transformation is due to the large investment and stewardship of the Governor and legislators to improve the behavioral health service delivery system. The movement toward managed care, the increased use of treatment alternatives to incarceration, the improved psychiatric crisis system, enhanced local community collaboration, and leveraged funding efforts have all contributed to significant

advancements in behavioral health care in Texas. Even with these improvements, there is room for advancement.

Texas currently invests $6.7 billion biennially at the state level through General Revenue, Medicaid, and local and federal dollars to fund behavioral health services at various state agencies that have not always coordinated efforts. In 2013, lawmakers created a statewide mental health coordinator position through the 2014–2015 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Health and Human Services Commission, Rider 82), to improve coordination among these state agencies and other entities and to provide statewide, strategic oversight on public mental health.

The Office of Mental Health Coordination (OMHC) has worked across state agencies to further these efforts through several statewide legislative initiatives. In 2015, the 2016–2017 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015, (Article IX, Section 10.04) created the Statewide Behavioral Health Coordinating Council, comprised of 18 state agencies that receive state funding for behavioral health services, to ensure these funds are spent efficiently and effectively. The Council was required to develop two key deliverables: a five-year strategic plan to coordinate and align behavioral health activities and an associated coordinated expenditure proposal for FY 2017. This work is guided by the Council's vision, "To ensure that Texas has a unified approach to the delivery of behavioral health services that allows all Texans to have access to care at the right time and place."

Pursuant to S.B. 55, 84th Legislature, Regular Session, 2015, the OMHC implemented the Texas Veterans + Family Alliance grant program which provides $20 million dollars in state grant funding across Texas to improve the quality of life of Texas veterans and their families by supporting local Texas communities to expand the availability of, increase access to, and enhance the delivery of mental health services. The office also expanded Mental Health First Aid training and created a comprehensive website for behavioral health resources. In addition, the OMHC supports a system-wide Behavioral Health Advisory Committee composed of statewide stakeholders. The newly formed committee under Sunset legislation also includes stakeholder input on children and youth behavioral health issues.

E.4.2 Texas Promoting Independence Initiative and Plan

The Promoting Independence Initiative began in January 2000 following the U.S. Supreme Court ruling in *Olmstead v. Zimring*, which requires states to provide long-term services and supports in the most integrated setting appropriate to the needs and wishes of individuals with disabilities. The Promoting Independence Initiative reflects the state’s commitment to providing meaningful opportunities for persons with disabilities to live in the community. The Initiative accomplishes this commitment through the delivery of services and supports that foster independence

and productivity while providing opportunities for individuals with disabilities to live in the setting of their choice. The Promoting Independence Initiative's scope is broad and includes, among other activities, the Money Follows the Person Demonstration Project, relocation and transition services, and housing navigators.

The Money Follows the Person Demonstration Project assists residents of Medicaid-certified nursing facilities and intermediate care facilities for individuals with an intellectual disability or related condition to relocate to a community setting via a Medicaid waiver program. Relocation services ensure the provision of assessments and case management to assist nursing facility residents who choose to relocate to community-based services and supports provided through contracted relocation specialists. Transition to Living in the Community is used to address Medicaid gaps in coverage. Housing navigators work with individuals in institutional settings who want to return to the community but have lost their community home. These individuals work with public housing authorities to help in securing affordable, accessible, and integrated housing.

E.4.3 Border Regions

The U.S.-México border is defined as the area 100 kilometers (62.5 miles) north and south of the international boundary, according to the La Paz Agreement. The Texas-México border is comprised of 32 counties and stretches 1,254 miles from the Gulf of México to El Paso, Texas, with a population currently of 2.9 million residents. It is considered to be one of the busiest international boundaries in the world. It is important to recognize that most Texas border residents are Hispanic, at 88.1 percent, compared to only 34.4 percent of Texas non-border residents.[33] Notably, the Texas-México binational border area also includes two Native American Nations, the Kickapoo Traditional Tribe of Texas and the Ysleta Pueblo del Sur, creating tri-national regions in Eagle Pass and El Paso.

The Texas border population is characterized by high rates of poverty. Thirty percent of border residents have incomes below federal poverty guidelines compared to only 16.2 percent of Texas non-border residents.[34] According to the 2014 BRFSS age-adjusted estimates, 46.1 percent of Texas border residents ages 18-64 lack health insurance, compared to only 28.3 percent in the non-border counties of Texas. In Texas border counties, 32.5 percent of residents do not speak English well, compared to only 12.2 percent in Texas non-border counties.[35] Only 66.1 percent of Texas border residents ages 25 and older had completed a high school diploma or a general educational development test, compared to 82.7 percent of the residents of the Texas non-border counties.[36]

[33] 2015 Census projections from Texas DSHS Center for Health Statistics.
[34] ACS, computed from 5-year estimates, based on 2009-2013 data.
[35] Ibid.
[36] Ibid.

Among the most serious public health issues facing Texas border residents are certain infectious or communicable diseases, including tuberculosis (TB), and of particular concern, the higher prevalence of obesity and diabetes. According to the 2014 BRFSS, the prevalence of obesity is significantly higher among border counties (39.2 percent) compared to the non-border counties (32.0 percent). This situation sets the stage for a chronic disease burden that persists throughout the lifespan. Diabetes prevalence as diagnosed by doctors in the border region (15.4 percent) as compared to the non-border region (10.5 percent) remains especially high. True prevalence of diabetes is likely higher, as national data indicate approximately 27.8 percent of all diabetes cases go undiagnosed.[37] Border-specific considerations are factored into the action items in Goal 1 on population health of the DSHS Strategic Plan.

The Office of Border Affairs was established to improve the quality of health and human services in colonias and other communities along the Texas-Mexico border through the planning and coordination of services and the utilization of Promotoras (Community Health Workers). The office's Border Specialists are located in areas from El Paso to Harlingen. The office coordinates the dissemination of information and resources and works with systems and stakeholders to increase knowledge of and access to services. Services include: distributing and explaining bilingual information; educating colonia residents on programs and services; and assisting with applications for Medicaid, CHIP, TANF, and the Supplemental Nutrition Assistance Program.

E.4.4 Early Childhood Immunization

Vaccines improve quality of life and life expectancy by achieving and maintaining an environment free of vaccine-preventable diseases. Increasing immunization rates for vaccine-preventable diseases in Texas is a collaborative effort involving parents, providers, caregivers, and public-sector institutions. A key strategy for increasing early childhood immunizations is to increase public awareness about the need and benefits of vaccinations.

Tex. Gov't Code Section 2056.0022 states that, “Each state agency that has contact with families in this state either in person or by telephone, mail, or the Internet is required to include in the agency’s strategic plan a strategy for increasing public awareness of the need for early childhood immunizations.” HHSC is charged to identify the state agencies to which this section applies and notify the agencies of their duties pursuant to this section.

DSHS, as delegated by HHSC, will identify the state agencies to which this section applies and notify the agencies of their duties pursuant to the section. This will be an initiative that will happen during the time frame of the 2017–2021 Strategic Plan.

[37] NHANES, 2014.

Opportunities for further coordination and collaboration may be identified during this timeframe, and any action plans will be developed as needed and appropriate.

E.4.5 Foster Care Improvements Steering Committee

The Foster Care Improvements Steering Committee (FCISC) is an ongoing committee that was created in August 2015 to support improvements for children in foster care. The committee was created in order to ensure there was coordination and communication across all the partners who have a role in the foster care system. Leadership was chosen as co-chairs to ensure that the Committee had ample decision-making authority.

The committee assists with the coordination and alignment of the multiple initiatives to support improvements in foster care, including efforts related to serving children with high needs and ongoing work to build foster care capacity. It serves as a central point for elevation of issues, as well as for cross-system work and solutions. Through this function, FCISC addressed an issue that would have limited the possibility for successful implementation of S.B. 125, 84th Legislature, Regular Session, 2015, that required children entering foster care to receive a comprehensive assessment within 45 days.

The committee is composed of representatives from various programs within the HHS System and the STARHealth managed health plan, and it is co-chaired by the Associate Commissioner of DFPS and the HHSC Medicaid Director. FCISC successfully:

- Identifies and addresses communication gaps among partners who serve children in foster care through regional coalition-building and hosting training opportunities for internal and external staff, and
- Maintains a work plan to decrease the number of clients waiting for their Determination for Intellectual Disability, required to determine eligibility for long-term services and supports.

E.4.6 Women's Health Services Coordination Initiative

The Women's Health Services (WHS) Division is comprised of programs committed to positively impacting women and families through quality health services. The current services and programs include the Texas Women's Health Program, the Family Planning Program, the Expanded Primary Health Care Program, and the Breast and Cervical Cancer Screening Program. In order to receive services, clients must meet certain eligibility requirements. For all programs, eligibility is determined by residency status, income level, family size, and health care needs. The Healthy Texas Women program, set to launch on July 1, 2016, replaces the Texas Women's Health Program and the Expanded Primary Health Care program.

WHS is responsible for the coordination and collaboration of the Better Birth Outcomes Workgroup. This workgroup holds monthly meetings with HHS agencies on women's health issues, focusing on maternal and child health. The workgroup initiatives are intended to: increase the number of women receiving preventive care services; increase early detection of breast and cervical cancers; avert unintended Medicaid births; reduce the number of preterm births; and reduce the number of cases of potentially preventable hospitalizations related to hypertension and diabetes. The workgroup has several successful projects in FY 2016 including the recent Long-Acting Reversible Contraceptive initiative that saves $7 in Medicaid and healthcare for every $1 spent on contraceptives and the Postpartum Depression Awareness campaign which highlights the importance of mental health treatment.

E.4.7 Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

The 82nd Legislature, 2011, directed HHSC to expand Medicaid managed care to achieve cost savings and to preserve hospital access to funding consistent with upper payment limit (UPL) funding. The best approach to meet legislative mandates and improve quality was to negotiate a five-year 1115 waiver that began in 2011. An 1115 waiver is a waiver under section 1115 of Social Security Act that allows the Centers for Medicare & Medicaid Services (CMS) and states more flexibility in designing programs to ensure delivery of Medicaid services. The Texas Healthcare Transformation and Quality Improvement 1115 waiver provides flexibility for Texas to preserve UPL funding while expanding risk-based managed care statewide by creating two new funding pools. The Uncompensated Care pool reimburses costs for care provided to individuals with no third-party coverage and for Medicaid costs in excess of Medicaid payments for hospital and other services. The Delivery System Reform Incentive Payment pool, a new incentive program, supports coordinated care and quality improvement goals through projects implemented in 20 Regional Healthcare Partnerships (RHPs). Texas' 1115 Waiver began December 10, 2011, and expires September 30, 2016. In May 2016, CMS approved a 15-month extension, taking the program through December 2017 and maintaining current funding. During this initial extension period, HHSC and CMS will continue negotiating a longer term extension. HHSC collaborates with many federal, state, local, and regional partners, including CMS, the Executive Waiver Committee, intergovernmental entities, anchoring entities, performing providers, external stakeholders, RHPs, and RHP participants.

E.4.8 STAR Kids Program

S.B. 7, 83rd Legislature, Regular Session, 2013, directed HHSC to provide Medicaid benefits to individuals with disabilities younger than age 21. In October 2015, HHSC contracted with 10 managed care organizations (MCOs) to administer the STAR Kids program. Beginning November 2016, children and youth age 20 or younger

who either receive Supplemental Security Income Medicaid or are enrolled in the Medically Dependent Children Program (MDCP) will receive all of their services through a STAR Kids health plan. Children and youth who receive services through other 1915(c) waiver programs will receive their basic health services (acute care) through STAR Kids. STAR Kids will be tailored to meet the needs of youth and children with disabilities. The program will provide benefits such as prescription drugs, hospital care, primary and specialty care, preventive care, personal care services, private duty nursing, and durable medical equipment and supplies. Children and youth who get additional services through MDCP will receive additional long-term services and supports through STAR Kids. Through STAR Kids, families also can expect coordination of care. Each health plan will provide service coordination that will help identify needs and connect members to services and qualified providers. Each member will have service needs assessed, which will form the basis of that member's individual service plan. Children, youth, and their families will have the opportunity to choose between at least two STAR Kids health plans and will have the option to change plans after their initial selection.

Critical for successful implementation is the system automation of the STAR Kids screening assessment, which requires system development and significant coordination among several entities, including the HHSC Medicaid and CHIP Division, the HHSC Office of Social Services, HHSC IT, Texas Integrated Eligibility and Redesign System (TIERS), HHSC Communications, DADS, DSHS, MCOs, eligibility verification vendors, Medicaid Management Information Systems vendors, the STAR Kids Managed Care Advisory Committee, and the Policy Council for Children and Families. HHSC welcomes input regarding the development and implementation of the STAR Kids program.

E.4.10 Veteran Services Division

The Veteran Services Division was created in 2013 and designed to coordinate, strengthen, and enhance veteran services across state agencies. Its focus is to review and analyze current programs, engage the charitable or nonprofit communities, and create public-private partnerships to benefit those programs. The division developed and disseminated the Texas Veterans App as a free-of-charge mobile phone application for veterans, active duty military, families, providers, and any Texan who supports our military. It allows the user to obtain information about the local, state, and national resources available to Texas military veterans.

Schedule F.1: Health and Human Services System Strategic Staffing Analysis and Workforce Plan for the Planning Period 2017–2021

Executive Summary

The Health and Human Services (HHS) System Strategic Staffing Analysis and Workforce Plan is an integral part of HHS' staffing plan. Workforce planning is a business necessity due to a number of factors, including:

- constraints on funding;
- increasing demand for HHS services;
- increasing number of current employees reaching retirement age resulting in fewer, less experienced workers available as replacements; and
- increasing competition for highly skilled employees.

HHS agencies are proactively addressing this challenge by preparing for the future and reducing risks. Designed for flexibility, the HHS System Strategic Staffing Analysis and Workforce Plan allows HHS executive management to make staffing adjustments according to the changing needs of HHS agencies.

State leaders in Texas recognize the importance of workforce planning. As part of their strategic plans, state agencies are required under the Texas Government Code, Section 2056.0021, to develop a workforce plan in accordance with the guidelines developed by the State Auditor's Office (SAO). To meet these requirements, this Schedule attachment to the HHS System Strategic Plan for the Fiscal Years 2017–2021 analyzes the following key elements for the entire HHS System:

- **Current Workforce Demographics** – Describes how many employees work for the HHS System and HHS agencies, where they work, what they are paid, how many of them are return-to-work retirees, how many have left HHS, how many may retire, and whether or not minority groups are underutilized when compared to the state Civilian Labor Force (CLF) for Equal Employment Opportunity (EEO) job categories. The workforce is examined by gender, race, age and length of state service.
- **Expected Workforce Challenges** – Describes anticipated staffing needs based on population trends, projected job growth and other demographic trends. A detailed examination of each identified shortage occupation was conducted to identify and understand retention and recruitment problems.
- **Strategies to Meet Workforce Needs** – Describes recruitment and retention strategies that address expected workforce challenges for shortage occupation jobs.

The following is the detailed HHS System Strategic Staffing Analysis and Workforce Plan.

HEALTH AND HUMAN SERVICES SYSTEM STRATEGIC STAFFING ANALYSIS AND WORKFORCE PLAN

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Prepared by: System Support Services
Human Resources Office

HEALTH AND HUMAN SERVICES SYSTEM

OVERVIEW

The 78th Legislature Transformation

The 78th Legislature (Regular Session, 2003) transformed the Health and Human Services (HHS) agencies listed in Article II of the General Appropriations Act by creating an integrated, effective and accessible HHS System that protects public health and brings high-quality services and support to Texans in need.

The HHS System consists of the following five agencies:

- **Health and Human Services Commission (HHSC).** Includes providing leadership to all HHS agencies, administering programs previously administered by the Texas Department of Human Services and oversight of HHS agencies. Began services in 1991.
- **Department of Family and Protective Services (DFPS).** Includes all programs previously administered by the Department of Protective and Regulatory Services. Began services on February 1, 2004.
- **Department of Assistive and Rehabilitative Services (DARS).** Includes programs previously administered by the Texas Rehabilitation Commission, Commission for the Blind, Commission for the Deaf and Hard of Hearing and Interagency Council on Early Childhood Intervention. Began services on March 1, 2004.
- **Department of Aging and Disability Services (DADS).** Includes intellectual and developmental disability and state supported living center programs previously administered by the Department of Mental Health and Mental Retardation, community care and nursing home services and long-term care regulatory programs of the Department of Human Services and aging services programs of the Texas Department of Aging. Began services on September 1, 2004.
- **Department of State Health Services (DSHS).** Includes programs previously administered by the Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse, the Health Care Information Council and mental-health community services and state hospital programs from the Department of Mental Health and Mental Retardation. Began services on September 1, 2004.

The 84th Legislature Transformation

In 2013, the Sunset Commission began its almost two-year analysis, the first formal review of the previous consolidation. The findings and recommendations of the Sunset review formed the basis for the 84th Texas Legislature's directive to transform the HHS system. With the passage of that legislation, HHS was given an opportunity to develop a more fully streamlined, efficient system that more effectively

provides services and benefits. Senate Bill 200 outlined a phased approach to this restructuring.

The first phase transfers the following programs and functions to HHSC by September 1, 2016:

- select functions at DARS,
- client services at DADS and DSHS, and
- administrative services that support those respective HHS core services.

As a result of this transfer and the transfer of other programs to the Texas Workforce Commission (TWC), DARS will be abolished on September 1, 2016. Additionally, the Nurse Family Partnership and Texas Home Visiting programs transfer from HHSC to the DFPS, which will continue its focus on protective services.

In the second phase, regulatory programs as well as management of the operations of the state supported living centers and state hospitals will transfer to HHSC by September 1, 2017, and DADS will be abolished. After these transfers, DSHS' streamlined structure will focus on its core public health functions.

HHS MISSION

Improving the health, safety and well-being of Texans through good stewardship of public resources.

HHS VISION

Making a difference in the lives of the people we serve.

HHS VALUES

- Accountability. We operate in a manner that reflects honesty, integrity and reliability.
- Collaboration. We work with clients, stakeholders, public and private partners, elected officials and our employees to make informed decisions and achieve excellence in service design and delivery.
- Client-focused. We exist because people have needs, and we respect each and every person.
- Independence. Our services and supports allow clients to reach their full potential.

- Stewardship. We are focused on the appropriate use of resources entrusted to our care and use them efficiently, effectively and in a manner that builds public trust.
- Transparency. We build confidence in our operations by being open, inclusive and holding ourselves accountable.
- Diversity. We offer programs and services that value and respect the diversity of the State of Texas.

WORKFORCE DEMOGRAPHICS

With a total of 54,018 full-time and part-time employees, the HHS workforce has increased by about one percent (545 employees) in the period from August 31, 2013 to August 31, 2015.[1]

Figure 1: HHS System Workforce for FY 13 - FY 15

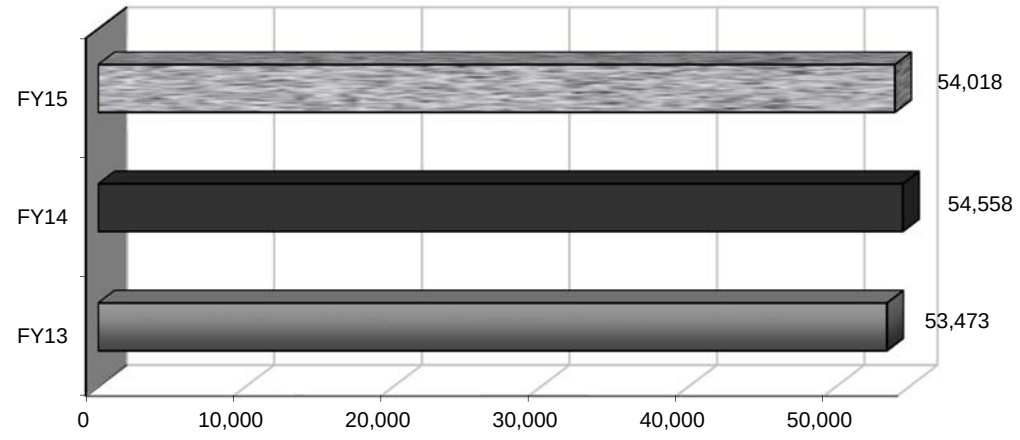
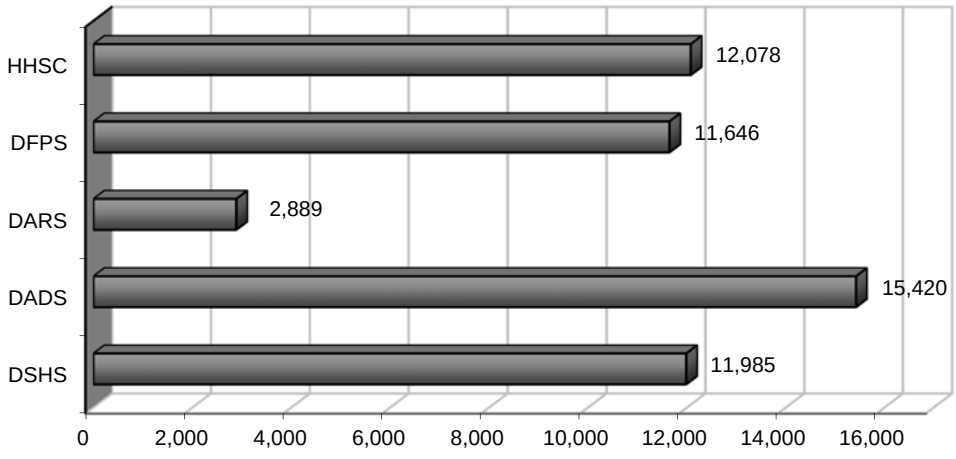


Figure 2: HHS System Workforce for FY 15



[1] HHSAS Database, as of 8/31/15.

Job Families

Approximately 91 percent of HHS employees (49,219 employees) work in 20 job families.[2]

Table 1: Largest Program Job Families

Job Family	Number of Employees
Direct Care Workers[3]	9,115
Human Services Specialists	7,003
Protective Services Workers[4]	6,596
Eligibility Workers[5]	5,995
Clerical Workers	5,399
Program Specialists	2,969
Registered Nurses (RNs)[6]	1,967
Manager	1,249
Licensed Vocational Nurse (LVNs)	1,028
Rehabilitation Technicians	1,010
CPS Supervisors	1,009
Food Service Workers[7]	925
System Analysts	883
Human Services Technicians	735
Custodians	707
Maintenance Workers	581
Program Supervisors	576
Inspectors	569
Claims Examiners	460
Accountants	443

Gender

Most HHS employees are female, making up about 75 percent of the HHS workforce.[8] This breakdown is consistent across all HHS agencies.[9]

[2] HHSAS Database, as of 8/31/15.
[3] Direct care workers include direct support professionals and psychiatric nursing assistants.
[4] Protective service workers include child protective service (CPS) specialists, CPS investigators, adult protective service (APS) specialists, state wide intake (SWI) specialists, Child Care Licensing (CCL) and residential licensing services (RCCL) specialists.
[5] Eligibility workers include Texas works advisors, hospital based workers and medical eligibility specialists.
[6] RNs include public health nurses.
[7] Food service workers include food service workers, managers and cooks.
[8] HHSAS Database, as of 8/31/15.
[9] Ibid.

Table 2: HHS System Workforce Gender for FY 13 – FY 15			
Gender	FY 13	FY 14	FY 15
Male	25.1%	24.9%	24.9%
Female	74.9%	75.1%	75.1%

Figure 3: HHS System Workforce by Gender for FY 15

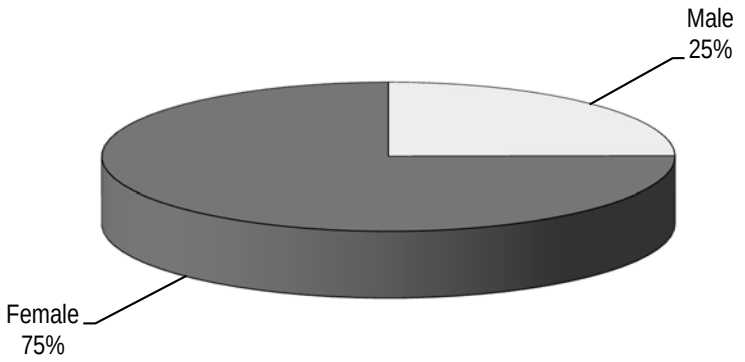


Table 3: HHS Agencies by Gender		
Agency	Percentage Male	Percentage Female
HHSC	21.2%	78.8%
DFPS	15.8%	84.2%
DSHS	36.0%	64.0%
DARS	24.4%	75.6%
DADS	26.2%	73.8%

Race

The workforce is diverse, with approximately 39 percent White, 30 percent Hispanic, 28 percent Black, and three percent Asian and Native American. This breakdown is consistent across all HHS agencies.[10]

[10] HHSAS Database, as of 8/31/15.

Table 4: HHS System Workforce Race for FY 13 – FY 15[11]			
Race	FY 13	FY 14	FY 15
White	40.6%	39.9%	39.4%
Black	27.4%	27.9%	28.1%
Hispanic	29.3%	29.3%	29.6%
Native American	.6%	.6%	.5%
Asian	2.1%	2.3%	2.3%

Figure 4: HHS System Workforce by Race for FY 15

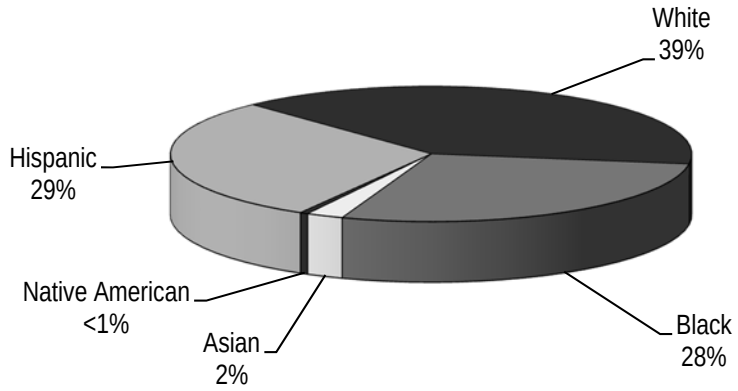


Table 5: HHS Agencies by Race[12]					
Agency	Percentage White	Percentage Black	Percentage Hispanic	Percentage Native American	Percentage Asian
HHSC	30.6%	28.3%	38.6%	0.6%	1.9%
DFPS	39.7%	29.2%	29.1%	0.6%	1.3%
DSHS	48.8%	19.0%	28.4%	0.6%	3.3%
DARS	46.4%	22.7%	28.1%	0.7%	2.2%
DADS	37.5%	35.4%	24.0%	0.4%	2.7%

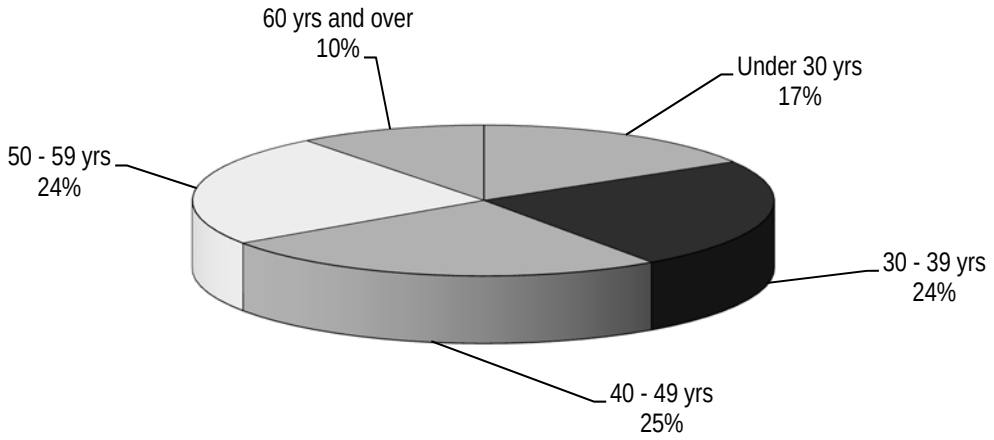
Age

The average age of an HHS worker is 43 years. This breakdown is consistent across all HHS agencies.[13]

[11] Totals may not equal 100% due to rounding.
[12] Ibid.
[13] HHSAS Database, as of 8/31/15.

Table 6: HHS System Workforce Age for FY 13 – FY 15			
Age	FY 13	FY 14	FY 15
Under 30	16.3%	16.8%	16.4%
30-39	22.9%	23.5%	23.8%
40-49	26.1%	25.5%	25.1%
50-59	24.8%	24.2%	24.1%
Over 60	9.9%	10.1%	10.4%

Figure 5: HHS System Workforce by Age for FY 15



Average age: 43 yrs

Table 7: HHS Agencies by Age[14]					
Agency	Percentage Under 30	Percentage 30-39	Percentage 40-49	Percentage 50-59	Percentage 60 and over
HHSC	10.6%	24.8%	29.7%	25.5%	9.4%
DFPS	20.5%	32.4%	24.8%	16.2%	6.2%
DSHS	16.0%	20.0%	22.9%	27.4%	13.7%
DARS	6.6%	20.0%	27.5%	30.6%	15.3%
DADS	20.1%	20.4%	23.2%	25.3%	11.0%

Utilization Analysis

Texas law requires that each state agency analyze its workforce and compare the number of Blacks, Hispanics and females employed by the agency to the available state Civilian Labor Force (CLF) for each job category.

[14] Totals may not equal 100% due to rounding.

The utilization analysis was conducted for each HHS agency using the 80% Rule. This rule compares the actual number of employees to the expected number of employees based on the available state CLF for Black, Hispanic and female employees. For purposes of this analysis, a group is considered underutilized when the actual representation in the workforce is less than 80% of what the expected number would be based on the CLF.

The HHS Civil Rights Office (CRO) reviewed and conducted analyses for each individual agency's workforce to determine where underutilization was identified.

The utilization analysis of the HHS agencies for fiscal year 2015 indicated underutilization in the DADS and DSHS workforce. The following table summarizes the results of the utilization analysis for the agencies of the HHS System.

Table 8: HHS System Utilization Analysis Results[15] [16] [17]

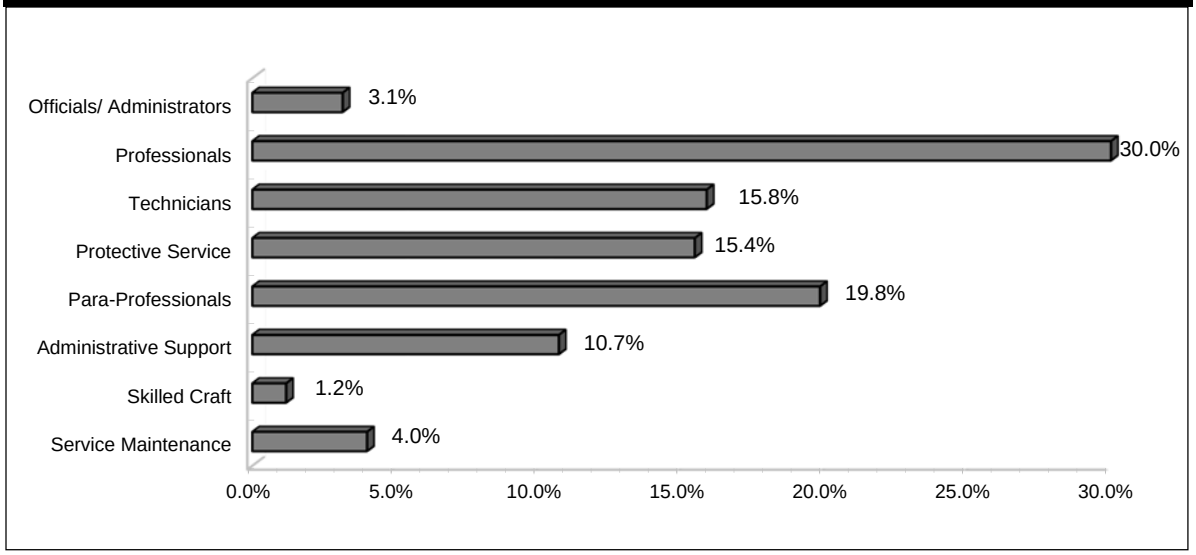
Job Category	HHS System	Agency				
		HHSC	DFPS	DARS	DADS	DSHS
Officials/ Administrators	No	No	No	No	**Hispanic**	No
Professionals	No	No	No	No	No	No
Technicians	No	No	No	N/A	**Hispanic**	No
Protective Service	No	N/A	No	N/A	No	**Hispanic Female**
Administrative Support	No	No	No	No	No	No
Skilled Craft	**Black Hispanic**	N/A	N/A	N/A	**Hispanic**	**Hispanic**
Service Maintenance	**Hispanic**	N/A	N/A	N/A	**Hispanic**	**Hispanic**

Although underutilization was identified in the Skilled Craft job category, it should be noted that this job category comprises only 1.2 percent of the HHS System workforce.

The other job categories showing underutilization are Officials/Administrators, Technicians, Protective Service, and Service Maintenance.

[15] HHSAS Database, as of 8/31/15.
[16] Data for underutilization percentages comes from Civilian Labor Force (CLF) Equal Employment Opportunity and Minority Hiring Practices Report Fiscal Years 2013-2014 published by Texas Workforce Commission, January 2015. Note: CLF data from TWC did not include Para-Professionals as a job category and did not indicate if members of that category were counted as part of any other categories - as a result, it is not included in the above chart.
[17] "N/A" indicates the number of employees in these categories was too small (less than 30) to test any differences for statistical significance.

Figure 6: HHS System – Percent of Employees by Job Category



State Service

Approximately 38 percent of the workforce has 10 or more years of state service. Less than a quarter of the workforce have been with the state for less than two years. This breakdown is consistent across all HHS agencies.[18]

Table 9: HHS System Workforce
Length of State Service for FY 13 – FY 15[19]

State Service	FY 13	FY 14	FY 15
less than 2 years	20.9%	22.7%	21.1%
2-4 years	18.8%	17.9%	17.9%
5-9 years	20.4%	21.5%	22.5%
10 years or more	39.8%	37.9%	37.5%

[18] HHSAS Database, as of 8/31/15.
[19] Totals may not equal 100% due to rounding.

Figure 7: HHS System Workforce by Length of State Service

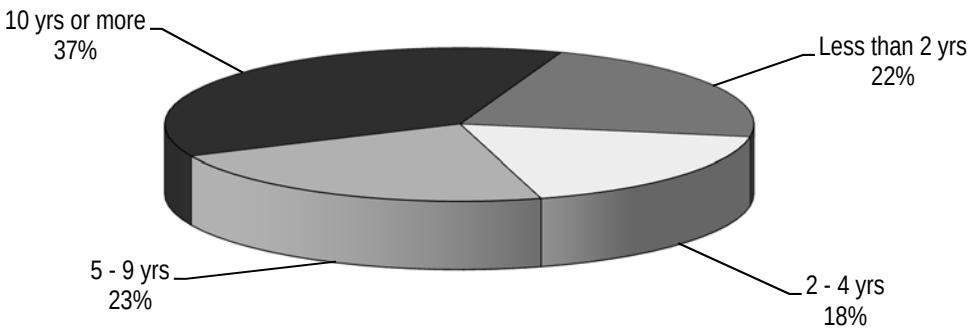


Table 10: HHS Agencies by Length of State Service[20]

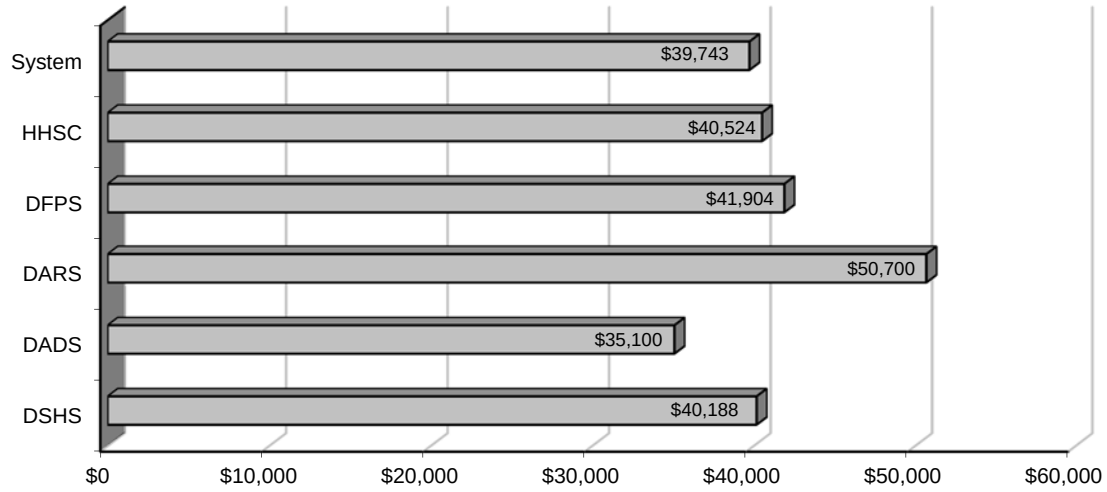
Agency	Percentage Less than 2 yrs	Percentage 2-4 yrs	Percentage 5-9 yrs	Percentage 10 yrs or more
HHSC	18.1%	16.7%	25.0%	40.2%
DFPS	24.7%	17.7%	25.2%	32.5%
DSHS	22.3%	17.9%	19.9%	39.9%
DARS	11.4%	10.9%	21.2%	56.5%
DADS	25.2%	20.5%	20.6%	33.8%

Average Annual Employee Salary

On average, the annual salary for an HHS System employee is $39,743. DARS has the highest average annual salary at $50,700 and DADS has the lowest at $35,100.[21] [22]

[20] Totals may not equal 100% due to rounding.
[21] HHSAS Database, as of 8/31/15.
[22] DFPS average salary includes CPS Stipend pay (CPI).

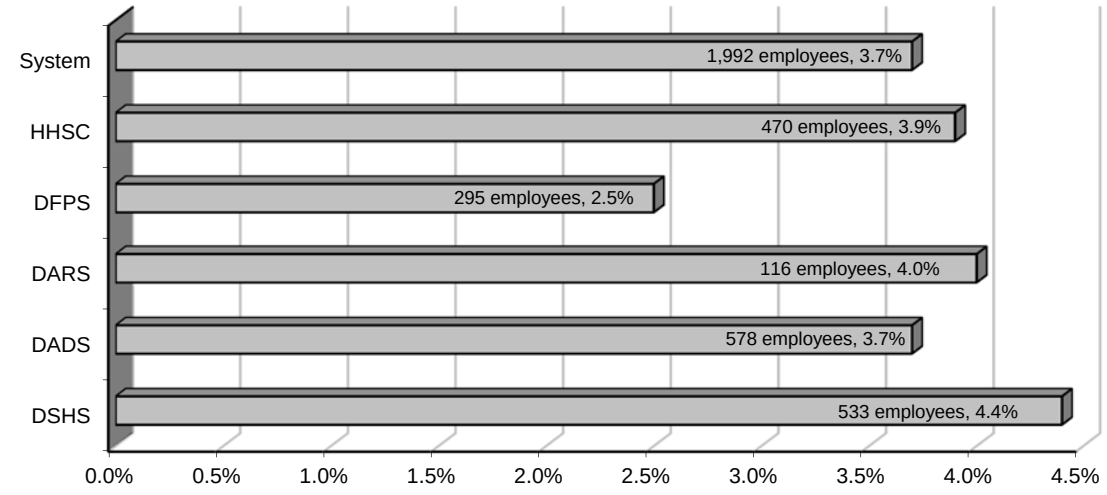
Figure 8: HHS Average Annual Salary by Agency



Return-to-Work Retirees

HHS agencies routinely hire retirees to support both ongoing operational needs and to assist in implementing new initiatives. When recruiting for shortage occupations, special skill required positions or for special projects, retirees provide a good source of relevant program-specific knowledge. Rehired retirees constitute about four percent of the total HHS workforce.[23]

Figure 9: HHS Return-to-Work Retirees by Percent of Workforce



[23] HHSAS Database, as of 8/31/15.

HHS management understands that demographic trends over the next decade will increasingly impact recruitment from typical sources. Retired workers who have institutional knowledge will be needed to pass their expertise to others.

Dealing with this aging workforce will require HHS agencies to attract more people to apply for work, encourage them to work longer and help make them more productive. Creative strategies will need to be devised to keep older workers on the job, such as hiring retirees as temps; letting employees phase into retirement by working part time; having experienced workers mentor younger employees; promoting telecommuting, flexible hours and job-sharing; urging retirement-ready workers to take sabbaticals instead of stepping down; and/or offering bonuses to forestall retirement.

Legislative changes have posed additional challenges for recruiting these retired workers. Beginning September 1, 2009, the amount of time a retired employee must wait before returning to state employment increased from 30 to 90 days. In addition, state agencies that hire return-to-work retirees must pay the Employees Retirement System of Texas (ERS) a surcharge that is equal to the amount of the State's retirement contribution for an active employee.

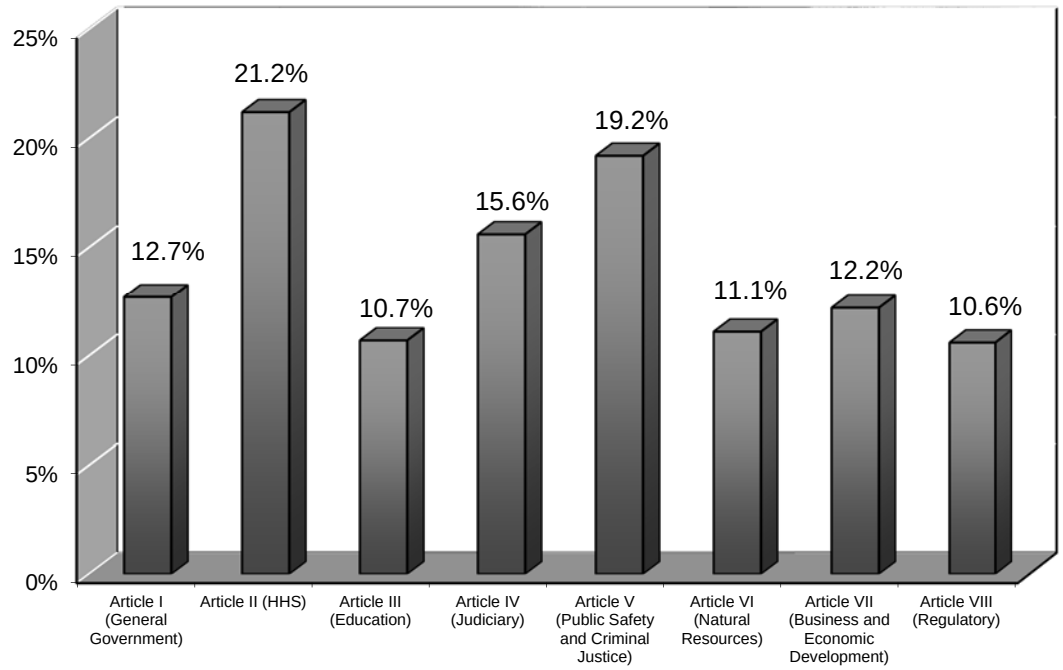
Of special concern to HHS is the possibility that the current practice of rehiring retirees may inhibit talented staff from moving into management or other senior positions. To address this problem and ensure that HHS considers and documents the selection of retirees, the System has adopted a requirement that before offering a supervisory position to a retiree, the hiring authority must document that:

- the retiree is the only candidate qualified to occupy the position; or is the best qualified candidate for the position; and
- the agency or program efficiency, quality, or effectiveness will improve if the retiree is selected, or deteriorate unless the retiree is selected.

TURNOVER

The Article II (HHS agencies) employee turnover rate during fiscal year 2015 was 21.2 percent, as identified by the State Auditor's Office (SAO). When compared to the turnover rates of other General Appropriations Act articles, HHS agencies had the highest turnover rate.[24]

Figure 10: Turnover Rate by Article for FY 15 (excludes inter-HHS agency transfers)



Note: The SAO does not consider it a loss when employees transfer between HHS agencies.

Table 11: HHS System Workforce - Turnover for FY 13 – FY 15 (excludes inter-HHS agency transfers)

Agency	FY 13	FY 14	FY 15
HHS System	20.8%	20.5%	21.2%

DADS experienced the highest turnover rate (32.2 percent), with the lowest turnover rate at DARS (12.8 percent).[25]

[24] State Auditor's Office, "An Annual Report on Classified Employee Turnover for Fiscal Year 2015," December 2014, Report No. 16-702, web page http://www.sao.state.tx.us/reports/main/16-702.pdf, last accessed 2/24/16.
[25] Ibid.

The SAO does not consider transfers between agencies as a loss to the state and therefore does not include this turnover in their calculations. However, when transfers between HHS agencies are taken into account, the HHS turnover rate increases from 21.2 percent to 23.3 percent. This additional turnover is significant because replacement costs are incurred by the agencies to process terminations and hires, to train new staff for different jobs and to recruit staff to replace those who have moved to another agency.[26]

Table 12: Turnover by HHS Agency for FY 15 (includes inter-HHS agency transfers)

Agency	Average Annual Headcount	Total Separations	Turnover Rate
HHSC	12,518	2,207	17.6%
DFPS	12,278	2,382	19.4%
DSHS	12,615	2,944	23.3%
DARS	2,967	380	12.8%
DADS	16,688	5,379	32.2%
Grand Total	**57,066**	**13,292**	**23.3%**

Of the total losses during fiscal year 2015, approximately 79 percent were voluntary separations and 21 percent were involuntary separations.[27] [28] Voluntary includes resignation, transfer to another agency and retirement. Involuntary includes dismissal for cause, resignation in lieu of separation, reduction in force and separation at will.[29]

[26] State Auditor's Office, "An Annual Report on Classified Employee Turnover for Fiscal Year 2015," December 2014, Report No. 16-702, web page http://www.sao.state.tx.us/reports/main/16-702.pdf, last accessed 2/24/16.
[27] Death accounted for .7% of separations.
[28] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[29] State Auditor's Office, "An Annual Report on Classified Employee Turnover for Fiscal Year 2015," December 2014, Report No. 16-702, web page http://www.sao.state.tx.us/reports/main/16-702.pdf, last accessed 2/24/16.

Table 13: Reason for Separation		
Reason	Separations	Percentage[30]
Voluntary Separations		
Personal reasons	7,840	59.0%
Transfer to another agency	1,203	9.0%
Retirement	1,396	10.5%
Involuntary Separations		
Termination at Will	51	0.4%
Resignation in Lieu	319	2.4%
Dismissal for Cause	2,400	18.1%
Reduction in Force	9	0.1%

Certain job families have significantly higher turnover than other occupational series, including direct care workers[31] at 42.5 percent, licensed vocational nurses (LVNs) at 35.0 percent, food service workers[32] at 34.6 percent, dentists at 32.3 percent, and registered nurses[33] (RNs) at 26.7 percent.[34]

[30] Death accounted for 0.6% of separations (76 separations).
[31] Direct care workers include DADS direct support professionals and DSHS psychiatric nursing assistants.
[32] Food service workers include food service workers, managers and cooks.
[33] RNs include public health nurses.
[34] HHSAS Database for FY 2015.

Table 14: FY 15 Turnover for Significant Job Families[35]

Job Title	Average Annual Headcount	Separations	Turnover Rate
Direct Care Workers[36]	10,252	4,353	42.5%
Licensed Vocational Nurses (LVNs)	1,148	402	35.0%
Food Service Workers[37]	1,032	357	34.6%
Dentists	31	10	32.3%
Registered Nurses (RNs)[38]	2,131	570	26.7%
Protective Services Workers[39]	7,078	1,768	25.0%
Psychologists[40]	258	64	24.8%
Epidemiologists	94	23	24.5%
Social Workers	204	47	23.0%
Physicians	95	21	22.1%
Psychiatrists	141	31	22.0%
Pharmacists	100	20	20.0%
Eligibility Workers	6,348	1,262	19.9%
Laboratory Technicians	55	9	16.4%
IG Investigators	247	39	15.8%
Medical Technologists	70	11	15.7%
Inspector General's Office (IG) Auditors	105	15	14.3%
Microbiologists	137	19	13.9%
Claims Examiners	478	65	13.6%
Registered Therapists	275	36	13.1%
Nurse Practitioners and Physician Assistants	50	6	12.0%
Sanitarians	125	13	10.4%
Chemists	61	6	9.8%

[35] Turnover is calculated as follows: The total number of employees who terminated during the period DIVIDED BY the average number of employees on the last day of each quarter in the period plus the employees that terminated during the quarter TIMES 100 to produce a percentage.
[36] Direct care workers include direct support professionals and psychiatric nursing assistants.
[37] Food service workers include food service workers, managers and cooks.
[38] RNs include public health nurses.
[39] Protective service workers include child protective service (CPS) specialists, CPS investigators, adult protective service (APS) specialists, state wide intake (SWI) specialists, Child Care Licensing (CCL) and residential licensing services (RCCL) specialists.
[40] Includes psychologists, behavioral health specialists, and behavioral analysts.

RETIREMENT PROJECTIONS

Currently, about 12 percent of the HHS workforce is eligible to retire and leave state employment. About two percent of the eligible employees retire each fiscal year. If this trend continues, approximately 10 percent of the current workforce is expected to retire in the next five years.[41]

Table 15: HHS System Retirements - Percent of Workforce (FY 11 – FY 15)

Fiscal Year	Retirement Losses	Retirement Turnover Rate
2011	1,301	2.2%
2012	1,346	2.4%
2013	1,444	2.6%
2014	1,390	2.4%
2015	1,396	2.4%

Table 16: HHS System First-Time Retirement Eligible Projection (FY 15 – FY 20)

Agency	FY 15		FY 16		FY 17		FY 18		FY 19		FY 20	
HHSC	276	2.3%	366	3.0%	447	3.7%	430	3.6%	442	3.7%	474	3.9%
DFPS	142	1.2%	205	1.8%	256	2.2%	274	2.4%	293	2.5%	262	2.2%
DARS	76	2.6%	116	4.0%	130	4.5%	139	4.8%	126	4.4%	138	4.8%
DADS	329	2.1%	397	2.6%	451	2.9%	458	3.0%	442	2.9%	478	3.1%
DSHS	323	2.7%	411	3.4%	428	3.6%	481	4.0%	419	3.5%	459	3.8%
Grand Total	1,146	2.1%	1,495	2.8%	1,712	3.2%	1,782	3.3%	1,722	3.2%	1,811	3.4%

The loss of this significant portion of the workforce means the HHS agencies will lose some of their most knowledgeable workers, including many employees in key positions. Effective succession planning and employee development will be critical in ensuring there are qualified individuals who can replace those leaving state service.

[41] HHSAS Database, as of 8/31/15.

CRITICAL WORKFORCE SKILLS

The current climate of the information age, advances in technology, increasing population for the state, consolidation of services, right-sizing and outsourcing will continue to place increased emphasis on the demand for well-trained and skilled staff.

The outsourcing and self-service automation of major HR functions, such as employee selection, have made it critical for HHS managers and employees to improve and commit to a continual learning of human resource policy, employee development, conflict resolution, time management, project management and automation skills.

It is important for HHS to employ professionals who have the skills necessary for the development, implementation and evaluation of the health and human services programs. These skills include:

- Analytic/assessment skills;
- Policy development/program planning skills;
- Communication skills;
- Cultural competency skills;
- Basic public health sciences skills;
- Financial planning and management skills;
- Contract management skills; and
- Leadership and systems-thinking skills.

As the Spanish speaking population in Texas increases, there will be an increased need for employees with bilingual skills, especially Spanish-English proficiency.

In addition, most management positions require program knowledge and the majority of these jobs are filled through the promotion of current employees. As HHS continues to lose tenured staff, effective training will be needed to ensure that current employees develop the skills necessary to transfer into management positions.

To promote this staff development, HHS must continue to grow the skills and talents of managers as part of a plan for succession. HHS has demonstrated this belief by establishing a HHS Leadership Academy, a formalized interagency training and mentoring program that provides opportunities to enhance the growth of high-potential managers as they take on greater responsibility in positions of leadership. The primary goals of the academy are to:

- prepare managers to take on higher and broader roles and responsibilities;
- provide opportunities for managers to better understand critical management issues;
- provide opportunities for managers to participate and contribute while learning; and

- create a culture of collaborative leaders across the HHS system.

Through this planned development of management skills and the careful selection of qualified staff, HHS will continue to meet the challenges posed by increased retirements.

ENVIRONMENTAL ASSESSMENT

The Texas Economy

In 2011, the Texas economy emerged from the worldwide recession. Pre-recession Texas employment peaked at 10,639,900 jobs in 2008, a level that was surpassed by November of 2011. By January 2016, Texas added an additional 1,322,600 jobs.[42]

The Comptroller's office reported that in 2014, the Texas' real gross domestic product grew by 5.2 percent (compared to 2.4 percent for the U.S.). This continued economic recovery could have a profound impact on the recruitment and retention challenges facing HHS.[43]

Poverty in Texas

As the number of families living in poverty increases for the state, the demand for services provided by the HHS System will also increase.

The U.S. Department of Health and Human Services defined the poverty level for 2015 according to household/family size as follows:

- $24,250 or less for a family of four;
- $20,090 or less for a family of three;
- $15,930 or less for a family of two; and
- $11,770 or less for individuals.[44]

It is estimated that 17.2 percent of Texas residents live in families with annual incomes below the poverty level. This rate is slightly higher than the national poverty rate of 14.8 percent.[45] [46]

[42] "Comptroller's Weekly Economic Outlook," web page: http://thetexaseconomy.org/economic-outlook/, last accessed on 5/9/16.
[43] Ibid.
[44] "Annual Update of the HHS Poverty Guidelines," Federal Register (80 FR 3236), webpage: https://www.federalregister.gov/articles/2015/01/22/2015-01120/annual-update-of-the-hhs-poverty-guidelines, last accessed on 4/20/16. Note: Guidelines apply to the 48 Contiguous States and D.C.
[45] U.S. Census Bureau: State and County Quickfacts, webpage http://quickfacts.census.gov/qfd/states/48000.html, last accessed on 4/20/16.
[46] U.S. Census Bureau: State and County Quickfacts, webpage http://www.census.gov/quickfacts/table/PST045215/00, last accessed on 4/20/16.

Unemployment

Another factor that directly impacts the demand for HHS System services is unemployment. In Texas, the August 2015 statewide unemployment rate was 4.4 percent, below the national rate of 5.1 percent.[47] [48]

Other Significant Factors

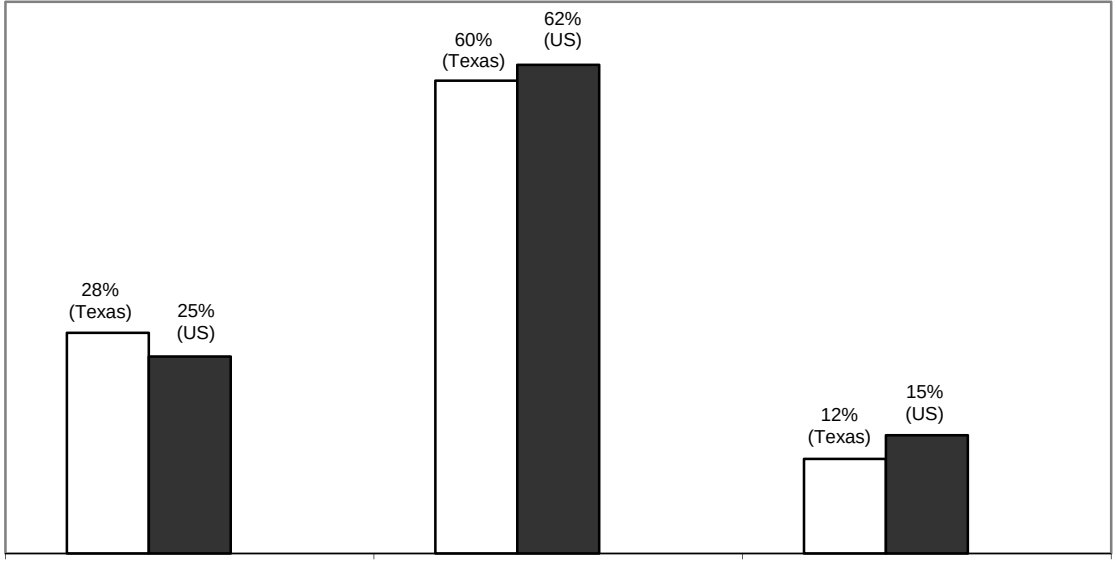
With over 27 million residents, Texas is one of the faster growing states in the nation. In just one period, April 1, 2010 to July 1, 2015, the population of Texas increased by more than two million, a 9.2 percent increase.[49] The Texas population is expected to continue to increase. By 2020, the Texas population is expected to reach nearly 30 million residents.[50]

As the overall percentage of Whites continues to decline, the Texas population will become increasingly diverse over the next five years. By the year 2020, the Hispanic population is expected to surpass the White population and become the majority of the Texas population by 2042.[51]

The distribution of age groups in Texas closely mirrors that of the nation, with the largest percentage of Texas residents (60 percent) being between ages 19 to 64, followed by those 18 and under (28 percent) and those 65 and over (12 percent).[52]

[47] Bureau of Labor Statistics, seasonally adjusted unemployment rate, web page http://data.bls.gov/timeseries/LASST480000000000003?data_tool=XGtable, last accessed on 5/9/16.
[48] Bureau of Labor Statistics, seasonally adjusted unemployment rate, for 16 years and over, web page http://data.bls.gov/timeseries/LNS14000000?data_tool=XGtable, last accessed on 5/9/16.
[49] American Fact Finder, U.S. Census Bureau, web page: http://www.census.gov/quickfacts/table/PST045215/48, last accessed on 5/9/16.
[50] Office of the State Demographer, Texas State Data Center.
[51] Policy Alert Supplement, November 2005, The National Center for Public Policy and Higher Education, web page http://www.highereducation.org/reports/pa_decline/states/TX.pdf, last accessed on 1/12/06.
[52] The Kaiser Family Foundation, State Health Facts: Population by Age, based on U.S. Census Bureau's March 2015 Current Population Surveys, web page http://kff.org/other/state-indicator/distribution-by-age/, last accessed on 5/9/16. Note: Percentage totals may not equal 100 percent due to rounding.

Figure 11: Population Distribution by Age



Long term population projections by the Texas State Data Center estimate that by 2050, the number of persons older than age 65 will triple in size (from 2010-2050), approaching 7.9 million.[53] This projected aging of the Texas labor force may have a major impact on growth of the labor force by dramatically lowering the overall labor force participation rate.

[53] Lloyd B. Potter and Nazrul Hoque, "Texas Population Projections, 2010 to 2050," Office of the State Demographer, November 2014, web page http://osd.texas.gov/Resources/Publications/2014/2014-11_ProjectionBrief.pdf, last accessed on 5/9/16.

EXPECTED WORKFORCE CHALLENGES

HHS will need to continue to recruit and retain health and human services professionals, such as psychiatrists, physicians, psychologists, nurse practitioners, physician assistants, registered nurses, licensed vocational nurses, registered therapists, pharmacists, dentists, epidemiologists, sanitarians and laboratory staff. Additionally, certain jobs will continue to be essential to the delivery of services throughout the HHS System. Many of the jobs are low paying, highly stressful and experience higher than normal turnover, such as Eligibility Services staff, protective services workers (adult and children), Inspector General's Office staff, claims examiners, direct care workers (direct support professionals and psychiatric nursing assistants) and food service workers.

Direct Care Workers (Direct Support Professionals and Psychiatric Nursing Assistants)

There are about 9,115 direct care workers employed in HHS state hospitals and state supported living centers. These positions require no formal education to perform the work, but employees are required to develop people skills to effectively interact with consumers. The physical requirements of the position are difficult and challenging due to the nature of the work.

The pay is low, with an average hourly rate of $11.95.[54]

The overall turnover rate for employees in this group is very high, at about 43 percent annually.[55] Taking into account these factors, state hospitals and state supported living centers have historically experienced difficulty in both recruiting and retaining these workers. Little change is expected.

Direct Support Professionals

There are 6,187 direct support professionals in state supported living centers across Texas, representing approximately 11 percent of the System's total workforce.[56] These employees provide 24-hour direct care to over 4,000 people who reside in state supported living centers. They directly support these individuals by providing services including basic hygiene needs, dressing and bathing, general health care, and dining assistance. They support life-sustaining medical care such as external feeding and lifting individuals with physical challenges. A trained and experienced direct care staff is essential to ensure consumer safety, health and well-being.

There are no formal education requirements to apply for a job in this series; however, extensive on-the-job training is required. It takes six to nine months for a

[54] HHSAS Database, as of 8/31/15.
[55] HHSAS Database, FY 2015 data.
[56] HHSAS Database, as of 8/31/15.

new direct support professional to become proficient in the basic skills necessary to carry out routine job duties.

Employees who perform this work must interact with consumers on a daily basis. The work is performed in shifts throughout the day and night. The pay is low and the work is difficult and physically demanding.

A typical HHS direct support professional is 38 years old and has about six years of state service.[57]

Turnover for direct support professionals is very high, at about 46 percent. This is one of the highest turnover rates of any job category in the System, reflecting the loss of about 3,265 workers during fiscal year 2015. Within this job family, entry-level Direct Support Professional Is experienced the highest turnover at 56 percent. Turnover rates by location ranged from 28 percent at the El Paso State Supported Living Center to 76 percent at the San Angelo State Supported Living Center.[58]

The average hourly salary rate for these employees is $11.92 per hour.[59] The State Auditor's Office 2014 market index analysis found the average state salary for Direct Support Professional IIs to be three percent behind the market rate.[60]

To deal with these retention difficulties, several state supported living centers have used contract staff to provide required coverage. Aside from being costly, HHS has experienced other challenges and problems with contracted staff, since these staff do not work consistently with the consumers and are therefore not able to carry out program plans fully. Contract staff are often placed for a very short time and do not always work with the same consumers. This situation can result in disruptions to consumer's lives and the suspension of progress toward development goals.

To address these difficulties, a two percent salary increase was approved by the 84th Legislature. In addition, HHS has plans to increase entry-level salaries for new direct support professionals and for currently employed direct support professionals during fiscal years 2018 and 2019.

Retention of these workers remains a major challenge for the System. Maintaining required staffing levels of direct support professionals in state supported living centers is critical in meeting Intermediate Care Facilities for Persons with Intellectual Disability (ICF/ID) certification requirements.

[57] HHSAS Database, as of 8/31/15.
[58] HHSAS Database, FY 2015 data.
[59] HHSAS Database, as of 8/31/15.
[60] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.

Psychiatric Nursing Assistants

There are approximately 2,930 psychiatric nursing assistants employed in HHS state hospitals.[61] These positions require high school education or equivalency to perform the work; however, there is extensive on-the-job training.

Workers are assigned many routine basic care tasks in the state hospitals that do not require a license to perform, such as taking vital signs, and assisting with bathing, hygiene and transportation. These employees are required to interact with patients on a daily basis. They are likely to be the first to intervene during crisis situations, and are the frontline staff most likely to de-escalate situations to avoid the need for behavioral restraints. They also have a higher potential for on-the-job injuries, both from lifting requirements and intervention during crisis situations. Further complicating this situation, many of the applicants for these entry-level positions lack the experience needed to work with patients and often lack the physical ability necessary to carry out their job duties.

The work is performed in shifts throughout the day and night. The work is difficult and the pay is low. Psychiatric nursing assistants earn an average hourly wage of $12.01 per hour. The State Auditor's Office 2014 market index analysis found the average state salary for psychiatric nursing assistants ranged from eight to 11 percent behind the market rate.[62] [63]

The average psychiatric nursing assistant is about 39 years old and has an average of seven years of state service.[64]

Turnover for psychiatric nursing assistants is very high at about 34 percent, reflecting the loss of 3,196 workers during fiscal year 2015. Within this job family, entry-level Psychiatric Nursing Assistant Is experienced the highest turnover at 43 percent. Turnover rates by location ranged from 27 percent at the Austin State Hospital to nearly 60 percent at the Big Spring State Hospital.[65]

HHS is currently experiencing difficulty filling vacant psychiatric nursing assistant positions. Vacant positions are going unfilled for many months. Positions at the Austin State Hospital are remaining vacant, on average, for about five months, and vacant positions at the Rio Grande State Center remain vacant, on average, for more than six months.[66]

[61] HHSAS Database, as of 8/31/15.
[62] Ibid.
[63] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[64] HHSAS Database, as of 8/31/15.
[65] HHSAS Database, FY 2015 data.
[66] HHSAS Database, as of 8/31/15.

To address these difficulties, HHS may request an increase to all classifications in this job family based on market data. In addition, HHS has plans to increase entry-level salaries for new psychiatric nursing assistants and for currently employed direct support professionals during fiscal years 2018 and 2019.

Recruitment and retention of these employees remains a major challenge for the System.

Food Service Workers

HHS employs approximately 925 food service workers, with the majority (99 percent) working in state supported living centers and state hospitals across Texas.[67]

The physical requirements are very demanding and there are no formal education requirements. Since meals are prepared seven days a week, some of these employees are required to work on night and weekend shifts.

The average hourly rate paid to food service workers is $10.81. Turnover in food service worker positions is high, at 35 percent during fiscal year 2015.[68] The State Auditor's Office 2014 market index analysis found the average state salary for Cook IIs to be eight percent behind the market rate, and food service managers ranged from four to eight percent behind the market rate.[69]

Retention and recruitment of these workers remains a major challenge for the System.

Food Service Workers at State Supported Living Center

There are 585 food service workers employed in HHS state supported living centers throughout Texas.[70]

The typical food service worker is about 45 years of age and has an average of approximately nine years of state service.[71]

[67] HHSAS Database, as of 8/31/15. Note: Food service workers include food service workers, managers and cooks.
[68] Ibid.
[69] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[70] HHSAS Database, as of 8/31/15.
[71] Ibid.

Turnover in these food service worker positions is very high, at 37 percent. Turnover is at nearly 50 percent at the Corpus Christi and Lufkin state supported living centers.[72]

Food Service Workers at State Hospitals

There are 333 food service workers employed at HHS state hospitals and centers throughout Texas.[73]

The typical food service worker is about 43 years of age and has an average of about eight years of state service.[74]

Turnover in these food service worker positions is high, at 30 percent. Turnover was at over 50 percent at the Big Spring State Hospital and 45 percent at the Rusk State Hospital.[75]

Protective Services Workers

In 2014, there were 305,200 protective service worker jobs in the U.S., with a projected job growth of 6.2 percent by 2024.[76] [77]

There are approximately 6,600 protective services workers employed by HHS as child protective service (CPS) specialists, CPS investigators, adult protective service (APS) specialists, state wide intake (SWI) specialists, Child Care Licensing (CCL) and Residential Licensing Services (RCCL) Specialists, making up about 12 percent of the HHS System workforce.[78] [79] The average annual salary for these workers is $40,425.60, a salary below both the national and state average annual salary. Nationally, protective services workers earn $46,610 annually, while in Texas, the average annual salary is $41,760.[80]

The 84th Legislature (Regular Session, 2015) continued its support of ongoing improvements by authorizing funds to allow HHS to continue to provide the salary retention supplement of $5,000 established by the 79th Legislature (Regular Session, 2005) for CPS investigation caseworkers and supervisors. As a means for increasing worker retention, the 84th Legislature (Regular Session, 2015) also

[72] HHSAS Database, FY 2015 data.
[73] HHSAS Database, as of 8/31/15.
[74] Ibid.
[75] HHSAS Database, FY 2015 data.
[76] Occupational title used is child, family and school social workers.
[77] U.S. Department of Labor, Bureau of Labor Statistics, Selected Occupational Projections Data, web page http://data.bls.gov/projections/occupationProj, Period: May 2014; last accessed on 4/25/16.
[78] HHSAS Database, as of 8/31/15.
[79] Protective Service Worker total does not include CCL and RCCL inspectors.
[80] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 4/25/16.

authorized the payment of up to $300 per month for experienced employees to mentor new workers.

To retain trained, competent staff while providing the highest quality services for consumers over the next five years, HHS must:

- competitively recruit, retain and train quality staff to adequately manage increasing caseloads and provide quality services to clients;
- meet the training demands of new staff, explore innovative ways to improve skills and provide policy refresher training for supervisors and caseworkers; and
- maintain hiring efforts to fill protective services worker positions and Child Care Licensing (CCL) and Residential Licensing Services (RCCL) specialist positions that are experiencing high turnover.

Child Protective Services (CPS) Workers

Within the System, there are 5,485 filled CPS worker positions (1,906 CPS investigators and 3,579 CPS specialists). CPS workers are young (nearly 70 percent are under 40 years of age), with an average age of approximately 36 years and an average of about five years of state service. About 39 percent of these workers have less than two years of state service.[81]

Turnover with this group of employees is considered high, at about 26 percent. Turnover is highest for CPS Worker I positions, reaching 43 percent (representing the loss of 641 employees in fiscal year 2015).[82]

HHS is currently experiencing difficulty filling CPS worker positions. Vacant positions are going unfilled for an average of more than three months due to a shortage of qualified applicants available for work. Positions in the El Paso area remaining vacant, on average, for more than five months.[83]

As caseloads continue to increase, recruitment and retention of employees with an aptitude for CPS casework continues to be a challenge for HHS.

Statewide Intake Specialists (SWIs)

There are approximately 320 SWI specialists with HHS. With an average age of about 39, approximately 63 percent of these specialists are under 40 years of age. SWI specialists have an average of about eight years of state service, with about 23 percent having less than two years of state service.[84] [85]

[81] HHSAS Database, as of 8/31/15.
[82] HHSAS Database, FY 2015 data.
[83] HHSAS Database, as of 8/31/15.
[84] SWI specialists include Protective Services Intake Specialists I-V.
[85] HHSAS Database, as of 8/31/15.

While overall turnover for SWI specialists at 19 percent is only slightly above the state average rate of 18 percent, entry-level Protective Service Intake Specialist Is are experiencing much higher turnover at 42 percent.[86] [87]

HHS is currently experiencing difficulty filling vacant SWI specialist positions. Vacant positions are going unfilled, on average, for nearly five months due to a shortage of qualified applicants available for work.[88]

Adult Protective Services (APS) Specialists

HHS employs about 670 APS specialists. The typical APS specialist is 40 years of age and has an average of eight years of state service. About 47 percent of these employees have less than five years of state service.[89] [90]

APS specialist turnover is considered high at 23 percent. Certain regions of Texas experienced higher turnover than others, including Midland area at 37 percent and the San Antonio area at 32 percent. Entry-level APS Specialist Is experienced the highest turnover at 40 percent.[91]

With the aging of the Texas population, the HHS anticipates an increasing demand for adult protective services.

Child Care Licensing (CCL) and Residential Licensing Services (RCCL) Specialists

There are 411 CCL and RCCL specialists employed within the System who monitor, investigate and inspect child day-care facilities and homes, residential child care facilities, child-placing agencies and foster homes.[92] In addition, they conduct child abuse/ neglect investigations of children placed in 24-hour childcare facilities and child placing agencies licensed or certified by Residential Child Care Licensing.

The typical specialist is 38 years of age and has an average of eight years of state service. About 44 percent of these employees have less than five years of state service.[93] [94]

CCL and RCCL specialist turnover is high at 23 percent.[95]

[86] HHSAS Database, FY 2015 data.
[87] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[88] HHSAS Database, as of 8/31/15.
[89] Ibid.
[90] Ibid.
[91] HHSAS Database, FY 2015 data.
[92] CCL and RCCL specialists include CCL inspectors and specialists and RCCL inspectors and investigators.
[93] HHSAS Database, as of 8/31/15.
[94] Ibid.
[95] HHSAS Database, FY 2015 data.

In addition, HHS experienced difficulty filling vacant positions. With a high vacancy rate of 16 percent, vacant positions go unfilled for months.[96]

Considering these factors, retention of these employees is an ongoing challenge.

Eligibility Services Staff

Across the state, there are about 8,470 employees supporting eligibility determinations within the System, accounting for about 16 percent of the HHS System workforce.[97]

The majority of these individuals (7,968 employees or 94 percent) are employed as Texas works advisors, medical eligibility specialists, hospital based workers, eligibility clerks and eligibility supervisors.[98]

While overall turnover for Eligibility Services Staff is the same as the state average rate (at 18 percent), Texas works advisors and medical eligibility specialists are experiencing higher turnover (both at a rate of about 20 percent).[99] [100]

Texas Works Advisors

There are over 4,900 Texas works advisors within HHS that make eligibility determinations for SNAP, TANF, CHIP and Medicaid for children, families and pregnant women. The typical Texas works advisor is 41 years of age and has an average of about eight years of service.[101]

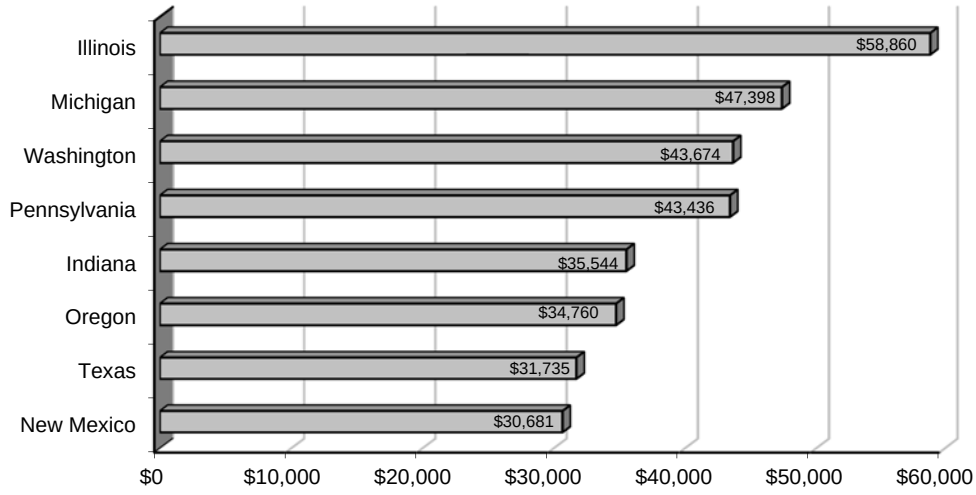
Turnover for these employees is high at about 20 percent, representing a loss of 1,048 workers in fiscal year 2015. Certain regions of Texas experienced higher turnover than others, including the Texas Panhandle at 30 percent and South Central Texas at 33 percent. Entry-level Texas Works Advisor Is experienced the highest turnover at 43 percent.[102]

In addition, HHS has experienced difficulty finding qualified candidates for new worker positions. Due to this shortage of qualified applicants, vacant positions go unfilled for an average of almost three months, with vacant positions in Southeast Texas remaining unfilled for an average of a little more than five months.[103]

[96] HHSAS Database, as of 8/31/15.
[97] HHSAS Database, as of 8/31/15.
[98] Ibid.
[99] HHSAS Database, FY 2015 data.
[100] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[101] HHSAS Database, as of 8/31/15.
[102] HHSAS Database, FY 2015 data.
[103] HHSAS Database, as of 8/31/15.

Salary is one factor that may be contributing to the System's difficulty recruiting and retaining eligibility workers. A 2010 Texas State Auditor's survey of the salary earned by tenured eligibility workers in 11 states indicated that Texas ranked near the bottom.[104]

Figure 12: Average Salaries for Tenured Eligibility Workers



Recruitment and retention of these employees remain a continuing challenge for HHS.

Medical Eligibility Specialists

Within HHS, there are 750 medical eligibility specialists determining financial eligibility for Medicaid for Elderly and People with Disabilities (MEPD). Medical eligibility specialists have, on average, about nine years of state service, with an average age of 42.[105]

Turnover for these employees is high at about 20 percent, representing the loss of 158 employees in fiscal year 2015. Entry-level Medical Eligibility Specialist Is experienced the highest turnover, at 37 percent.[106]

Retention of these specialists is an ongoing challenge.

[104] State Auditor's Office, "An Audit Report on the Supplemental Nutrition Assistance Program at the Health and Human Services Commission," March 2010, Report No. 10-026, web page http://www.sao.state.tx.us/reports/main/10-026.pdf, last accessed 3/26/15.
[105] HHSAS Database, as of 8/31/15.
[106] HHSAS Database, FY 2015 data.

Hospital Based Workers

HHS has about 300 hospital based workers stationed in nursing facilities, hospitals, and clinics rather than in eligibility offices to determine eligibility for the SNAP, TANF, CHIP and Medicaid programs. These highly-tenured workers have an average of about 15 years of state service (about 56 percent of these employees have 10 or more years of state service), with an average age of 46.[107]

Turnover for these employees is currently below the state average (of 18 percent) at about 16 percent.[108] [109]

Eligibility Clerks

HHS employs about 1,445 eligibility clerks in various clerical, administrative assistant and customer service representative positions. The typical eligibility clerk is 46 years of age and has an average of 10 years of state service.[110]

The turnover rate for eligibility clerks is high at about 18 percent, representing the loss of about 280 employees (a three percent lower rate than reported for fiscal year 2013).[111] [112] Eligibility Specialist Clerk IIIs made up the majority of these losses at about 75 percent, with these positions often remaining unfilled for an average of six months.[113] [114]

Recruitment and retention for these jobs are ongoing challenges.

Eligibility Supervisors

Approximately 530 eligibility supervisors are employed within HHS. These highly-tenured supervisors have an average of 19 years of state service (75 percent of these employees have 10 or more years of state service), with an average age of 48.[115]

Though turnover for these employees is well managed at about 10 percent, 22 percent of these employees are currently eligible to retire from state employment. Within the next five years, nearly half of these employees will be eligible to retire.[116]

HHS will need to develop effective succession plans and creative recruitment strategies to replace these highly skilled and tenured employees.

[107] HHSAS Database, as of 8/31/15.
[108] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[109] HHSAS Database, FY 2015 data.
[110] HHSAS Database, as of 8/31/15.
[111] HHSAS Database, FY 2013 data.
[112] HHSAS Database, FY 2015 data.
[113] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[114] HHSAS Database, as of 8/31/15.
[115] Ibid.
[116] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.

Inspector General's Office (IG) Staff

Across the state, there are about 680 IG employees within HHS. The majority of these individuals (424 employees or 62 percent) are employed as auditors, investigators, and registered nurses (RNs).[117] [118]

Auditors

There are about 150 auditor positions within HHS, with about 65 percent working in IG.[119] Of these staff, about 73 percent work in Audit Consolidated, and the remaining 27 percent are divided among numerous units within OIG, including Medicaid/CHIP Audit, WIC Vendor Monitoring, Hospital Audits and OIG Managed Care Operations.

IG auditors perform operational and performance audits of programs, processes and systems across HHS agencies. IG auditors are responsible for performing contractor and medical provider audits and reviews to help ensure compliance with state and federal laws, rules and regulations and to identify potential overpayments. Employees in these classifications prepare audit reports that make recommendations for increasing operational efficiency, strengthening management controls, mitigating business risks and improving compliance.

The typical IG auditor is about 51 years old and has an average of 14 years of state service.[120]

IG auditors earn an average annual salary of $53,323, which is below both the state and national average.[121] The average annual earnings for accountants and auditors in 2015 was $75,280 nationally, and $78,490 in Texas.[122] [123] In addition, the State Auditor's Office 2014 market index analysis found the average state salary for auditors ranged from seven to eight percent behind the market rate.[124]

[117] HHSAS Database, as of 8/31/15.
[118] IG RNs are discussed under the Registered Nurses subsection.
[119] HHSAS Database, as of 8/31/15.
[120] Ibid.
[121] Ibid.
[122] Ibid.
[123] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 5/2/16.
[124] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16. Note: Since there were no Auditor IIs in IG, data on the market rate for this classification were not included.

Though turnover for all IG auditors is below the state average of 18 percent (at 14 percent), turnover for Auditor IIIs is high at about 19 percent.[125] [126]

In addition, HHS may face significant recruitment challenges in the next few years to replace those employees who are eligible for retirement. More than a quarter of IG auditors are currently eligible to retire. In the next five years, this rate will increase to over 40 percent.[127]

To address these difficulties, HHS may create a career ladder for IG auditors, provide a salary equity adjustment, and increase entry-level salaries for new IG auditors and for currently employed IG auditors during fiscal years 2018 and 2019.

Investigators

Of the 367 investigators working for HHS agencies, 247 of them (67 percent) work within IG.[128] Nearly half of these employees work in the General Investigations section of the Enforcement Division, with the rest divided among numerous units within IG, including Criminal History Checks, Internal Affairs Consolidations, Medical Provider Integrity, and Sanctions.

The typical investigator is about 46 years old and has an average of 13 years of state service. More than half of these employees have 10 or more years of state service.[129]

IG investigators earn an average annual salary of $48,859, which is below both the state and national average.[130] The average annual earnings for investigators in 2015 was $69,180 nationally and $71,750 in Texas.[131] [132]

Though turnover for these highly-tenured employees is slightly below the state average of 18 percent (at 16 percent), Investigator VIs are experiencing high turnover at 24 percent.[133]

In addition, about 13 percent of these employees are currently eligible to retire from state employment. Within the next five years, 32 percent of these highly skilled and tenured employees will be eligible to retire.[134]

[125] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[126] HHSAS Database, FY 2013 data.
[127] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[128] HHSAS Database, as of 8/31/15.
[129] Ibid.
[130] HHSAS Database, as of 8/31/15.
[131] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 5/2/16.
[132] Occupational title used is Compliance Officers.
[133] HHSAS Database, FY 2013 data.
[134] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.

Recruitment and retention for these jobs will continue to be ongoing challenges.

To address these difficulties, HHS may create a career ladder for IG investigators, provide a salary equity adjustment, and increase entry-level salaries for new and currently employed IG investigators.

Claims Examiners

HHS employs 460 claims examiners, with the majority (99 percent) employed in the Division for Disability Determination Services (DDS).[135] These claims examiners have, on average, about 11 years of state service, with an average age of about 43 years.[136]

Entry-level DDS claims examiners must have a bachelor's degree and complete a two year training program before they are considered fully trained and able to work the various types of Social Security disability claims. Generally, it takes a minimum of two years for a DDS claims examiner to be fully competent in their knowledge of the complicated Social Security disability program.

Though DDS claims examiners are separating from employment at an annual rate of only 14 percent, the vacancy rate for claims examiners is currently high at about 24 percent, with vacant positions often going unfilled for an average of seven months due to a shortage of qualified applicants available for work. These vacancy problems are expected to worsen as employees approach retirement. Over 20 percent of these tenured and highly skilled employees will be eligible to retire in the next five years.[137] [138]

Due to cost of this extensive training that newly hired examiners must take to become fully competent in their job, continuous monitoring of retention of these employees will remain a priority for System management. In addition, as the Social Security Administration (SSA) allows for the filling of new approved vacancies, DDS will need to coordinate the timing of filling the new positions with the SSA to determine if DDS has the necessary resources (e.g. trainers, facility needs, etc.) to ensure all employees receive the required training and ongoing professional development.

Social Workers

There are 206 social workers employed by HHS, with the majority (99 percent) housed in state supported living centers and state hospitals across the state.[139]

[135] HHSAS Database, as of 8/31/15.
[136] Ibid.
[137] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[138] HHSAS Database, FY 2015 data.
[139] HHSAS Database, as of 8/31/15.

Turnover for these social workers is high at 23 percent.[140]

One reason for this high turnover is the large disparity between private sector and HHS salaries. System social workers earn an average annual salary of $42,010.[141] This salary falls significantly below the market rate. The average annual salary for social workers nationally is $54,020 and $55,510 in Texas.[142] The State Auditor's Office 2014 market index analysis found the average state salary for Social Worker IIs and IIIs was seven percent behind the market rate.[143]

These problems are expected to worsen as employees approach retirement. While 14 percent of these employees are currently eligible to retire, this number increases to nearly 25 percent in the next five years.[144]

Social Workers at State Supported Living Centers

About 16 percent of HHS social workers (33 employees) work at state supported living centers across the state.[145] These employees serve as a liaison between the individual, legally authorized representative and others to assure ongoing care, treatment and support through the use of person-centered practices. They gather information to assess an individual's support systems and service needs, support the assessment of the individual's rights and capacity to make decisions, and assist with the coordination of admissions, transfers, transitions and discharges.

The typical social worker at these facilities is about 44 years old and has an average of nine years of state service.[146]

While the overall turnover for these social workers is less than the state average of 18 percent (at 15 percent), positions often remaining unfilled for an average of five months before being filled. At the Abilene State Supported Living Center, social worker positions remain vacant for about seven months.[147] [148] [149]

[140] HHSAS Database, FY 2015 data.
[141] HHSAS Database, as of 8/31/15.
[142] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 5/2/16.
[143] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[144] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[145] HHSAS Database, as of 8/31/15.
[146] Ibid.
[147] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[148] HHSAS Database, FY 2015 data.
[149] HHSAS Database, as of 8/31/15.

HHS may face significant recruitment challenges in the next few years to replace these employees who will be eligible for retirement. About 18 percent of these employees will be eligible to retire in the next five years.[150]

Social Workers at State Hospitals

There are 171 social workers at HHS state hospitals.[151] These employees are critical to managing patient flow in state hospitals and taking the lead role in communicating with patient families and community resources. Social workers provide essential functions within state hospitals that include conducting psychosocial assessments, therapeutic treatment and case coordination for individuals receiving services from HHS in-patient psychiatric hospitals and the Waco Center for Youth.

State hospital social workers are about 42 years old and have an average of 10 years of state service.[152]

The overall turnover rate for these social workers is high at around 24 percent, with the Austin State Hospital and Big Spring State Hospital experiencing turnover of more than 30 percent.[153]

In addition, about 15 percent of these employees are currently eligible to retire. Within the next five years, 25 percent of these employees will be eligible to retire.[154]

Factors impacting recruitment include non-competitive salaries, credentialing requirements and increased need for individuals with Spanish-English bilingual skills. HHS competes with both federal and local governments, as well as the military and the private sector employers for social worker applicants. Many times the competitors are able to offer a higher starting salary.

Considering these factors, recruitment and retention for these jobs are ongoing challenges. To address these difficulties, HHS may consider increasing entry-level salaries for these social workers and for currently employed state hospital social workers during fiscal years 2018 and 2019.

Registered Therapists

HHS employs 274 registered therapists, with the majority (98 percent) working in state supported living centers and state hospitals across Texas.[155] HHS therapists are employed in a variety of specializations, including speech-language pathologists,

[150] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[151] HHSAS Database, as of 8/31/15.
[152] Ibid.
[153] HHSAS Database, FY 2015 data.
[154] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[155] HHSAS Database, as of 8/31/15.

audiologists, occupational therapists and physical therapists. Full staffing of these positions is critical to direct-care services.

These highly skilled employees have, on average, about eight years of state service, with an average age of 45.[156]

System registered therapists earn an average annual salary of $72,788.[157] The average annual salary for registered therapists nationally is $82,072 and $89,043 in Texas.[158] In addition, the State Auditor's Office 2014 market index analysis found the average state salary for registered therapists ranged from one to 26 percent behind the market rate.[159]

Though turnover for registered therapists is currently below the state average (at 13 percent), positions are remaining vacant for an average of about nine months.[160] [161]

About 22 percent of System registered therapists will be eligible to retire within the next five years. HHS will need to develop creative recruitment strategies to replace these highly skilled employees.[162]

Registered Therapists at State Supported Living Centers

About 78 percent for HHS registered therapists work at state supported living centers. These employees have, on average, about eight years of state service, with an average age of 45.[163]

Though turnover for these registered therapists is below the state average at 13 percent, HHS is experiencing difficulty filling vacant positions. Positions at the Abilene, Brenham, Mexia and San Angelo State Supported Living Centers remain unfilled for over 300 days.[164] [165] [166]

HHS may face significant recruitment challenges in the next few years to replace these highly skilled employees who will be eligible for retirement. Though only 10

[156] HHSAS Database, as of 8/31/15.
[157] Ibid.
[158] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 5/2/16. Note: Reported salaries represent the weighted average for occupational therapists, audiologists, speech-language pathologists and physical therapists.
[159] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[160] HHSAS Database, FY 2015 data.
[161] Ibid.
[162] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[163] HHSAS Database, as of 8/31/15.
[164] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[165] HHSAS Database, FY 2015 data.
[166] HHSAS Database, as of 8/31/15.

percent of these employees are currently eligible to retire, over 20 percent of them will be eligible in the next five years.[167] HHS will need to develop creative recruitment strategies to replace these highly skilled and tenured employees.

Registered Therapists at State Hospitals

HHS employs 57 registered therapists at state hospitals across Texas.[168]

These highly skilled employees have, on average, about 12 years of state service, with an average age of 46.[169]

Though turnover for these employees is currently below the state average of 18 percent (at 15 percent), the San Antonio State Hospital is experiencing high turnover for these employees at 26 percent.[170] In addition, positions at the North Texas State Hospital often remaining unfilled for over six months.[171]

Though only 12 percent of these highly skilled employees are currently eligible to retire, this number will increase to 26 percent in the next five years, making recruitment and retention for these jobs an ongoing challenge for the System.[172]

Registered Nurses (RNs)

The nation and Texas continue to face a shortage of RNs, which is predicted to worsen over the next twenty years as baby boomers age and the need for health care grows. With state nursing schools facing budget cuts, they may be less able to hire enough faculty members to train new nurses to meet projected needs.[173]

RNs constitute one of the largest healthcare occupations. With 2.7 million jobs in the U.S., job opportunities for RNs are expected to grow faster than the average for all occupations. It is projected that there will be a need for 439,300 new RN jobs by 2024. With this level of job growth, it is projected that there will not be enough qualified applicants to meet the increased demand.[174] [175] [176]

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[167] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[168] HHSAS Database, as of 8/31/15.
[169] Ibid.
[170] HHSAS Database, FY 2015 data.
[171] HHSAS Database, as of 8/31/15.
[172] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[173] "Has the Recession Solved the Nursing Shortage? Experts say No," Robert Wood Johnson Foundation, April 17, 2009, web page http://www.rwjf.org/pr/product.jsp?id=41728, last accessed 3/17/10.
[174] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, web page http://www.bls.gov/ooh/healthcare/registered-nurses.htm, last accessed on 3/16/16.
[175] U.S. Department of Labor, Bureau of Labor Statistics, Selected Occupational Projections Data, web page http://www.bls.gov/emp/ep_table_110.htm, last accessed on 3/16/16.
[176] Ibid.

Texas is also experiencing a critical shortage in RNs. It is projected that between 2005 and 2020, the demand for nurses in Texas will increase by 86 percent, while the supply will grow by only 53 percent.[177] Although numbers vary from study to study, most concur that the nursing shortage is the most severe health workforce shortage currently facing both the nation and Texas.[178] The Texas nurse-to-population ratio is below the national average of 921 nurses per 100,000 people, with the state ratio being only 753 nurses per 100,000 people.[179] [180]

Although there are 115 nursing school programs across the state, most of them have more applicants than room for new students and only about two-thirds of enrolled students actually graduate.[181] [182] The shortage of trained instructors limits both the number of accepted students and the number of available classes offered. Other factors contributing to the current shortage include the steep population growth (resulting in a growing need for health care services), an aging nursing workforce, an overall aging and service-demanding population and an increased need for specialized nursing skills. This crisis is emerging just as skilled nurses are retiring and job opportunities in health care are expanding. The projected rates of growth in the youth, elderly and minority populations in Texas will result in an increased demand for health services from HHS System agencies.

HHS employs approximately 1,967 RNs across the state, in state supported living centers, state hospitals, in Health Service Regions, and within the Inspector General's Office (IG).[183] [184] As the demand for nursing services increases and the supply decreases, the recruitment and retention of nurses becomes more difficult and the need for competitive salaries will become more critical.

[177] "Texas Nursing: Our Future Depends on It. A Strategic Plan for the State of Texas to Meet Nursing Workforce Needs of 2013," Texas Center for Nursing Workforce Studies, March 2009.
[178] State of Nursing Workforce in Texas – Statewide Health Workforce Symposium Policy Brief, March 2005.
[179] "Nursing Workforce in Texas - 2011: Demographics and Trends," Texas Center for Nursing Workforce Studies, January 2013. Web page http://www.dshs.state.tx.us/chs/cnws/Final2-NursingWorkforceDemoTrends2011.pdf, last accessed 5/12/14.
[180] "The U.S. Nursing Workforce: Trends in Supply and Education," Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis, April 2013. Web page http://bhpr.hrsa.gov/healthworkforce/reports/nursingworkforce/nursingworkforcefullreport.pdf, last accessed 5/15/14.
[181] Texas Board of Nursing, web page http://www.bne.state.tx.us/pdfs/education_pdfs/education_programs/ApprovedRNschools.pdf, last accessed on 5/9/14.
[182] "Professional Nursing Education in Texas: Demographics & Trends: 2006." Department of State Health Services, web page http://www.dshs.state.tx.us/chs/cnws/2006ProfNrsgEdRpt.pdf, last accessed 3/17/10.
[183] HHSAS Database, as of 8/31/15.
[184] RNs include public health nurses.

Currently, the average annual salary for RNs is $57,738.[185] This salary falls below both national and state averages for these occupations. Nationally, the average annual earnings for RNs in 2015 was $71,000.[186] In Texas, the average annual earnings for RNs in 2015 was $69,890.[187] In addition, the State Auditor's Office 2014 market index analysis found the average state salary for RNs ranged from five to 16 percent behind the market rate.[188] Many private hospitals are further widening the salary gap by offering signing bonuses. The non-competitive salaries offered by HHS agencies are directly contributing to the HHS System's difficulties recruiting qualified applicants. Posted vacant positions are currently taking about five months to fill. The System is also losing existing staff to higher paying private health care jobs at an alarming rate (turnover of 27 percent for fiscal year 2015).[189]

It is expected that recruitment and retention of nurses will continue to be a problem for the System, as the nursing workforce shortage continues and as a significant portion of System nurses approach retirement.

To address these difficulties, the 84th Legislature approved a targeted wage increase for RNs in localities with the highest turnover rates. In addition, HHS may consider increasing entry-level salaries for RNs and for currently employed RNs during fiscal years 2018 and 2019 and providing a salary equity adjustment for IG RNs.

RNs at State Supported Living Centers

About 35 percent of System RNs (690 RNs) work at HHS state supported living centers across Texas.[190]

The typical state supported living center RN is about 47 years old and has an average of approximately seven years of state service.[191]

The turnover rate for these RNs is considered high at about 29 percent. Turnover is especially high at the Lubbock State Supported Living Center (at 42 percent) and the El Paso State Supported Living Center (at 52 percent).[192]

In addition, HHS finds it difficult to fill these vacant nurse positions. At these facilities, there are always vacant nursing positions that need to be filled. With a high vacancy rate for these positions (at approximately 11 percent), RN positions

[185] HHSAS Database, as of 8/31/15.
[186] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 4/29/16.
[187] Ibid.
[188] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[189] HHSAS Database, FY 2015 data.
[190] HHSAS Database, as of 8/31/15.
[191] Ibid.
[192] HHSAS Database, FY 2015 data.

often remain open for more than five months before being filled. Some facilities are experiencing even longer vacancy durations. At the Brenham State Supported Living Center it takes about seven months to fill a position, while at the Austin State Supported Living Center, it takes nearly eight months.[193] In order to provide quality nursing care for consumers, it is essential that HHS maintain the lowest vacancy rate.

RNs at State Hospitals

About 42 percent of System RNs (817 RNs) work at state hospitals across the Texas, providing frontline medical care of patients. They provide medications, primary health care and oversee psychiatric treatment.[194]

System nurses at state hospitals are generally required to work shifts and weekends. The work is demanding, requires special skills and staff often work long hours with minimal staffing. The work is also physically demanding, making it increasingly more difficult for the aging nursing workforce to keep up with these work demands. All of these job factors contribute to higher than average turnover rates.

The typical RN at a System state hospital is about 48 years old and has an average of approximately 10 years of state service.[195]

The turnover rate for these RNs is considered high at about 28 percent. Turnover is especially high at the Rusk State Hospital, at 47 percent and within the Texas Center for Infectious Disease (at 42 percent).[196]

At these state hospitals, there are always vacant nursing positions that need to be filled. These RN positions often remain open for about five months before being filled. Some hospitals are experiencing even longer vacancy durations. At the North Texas State Hospital, it takes about seven months to fill a position, while at the Big Spring State Hospital, it takes nearly nine months.[197]

Public Health RNs

About 10 percent of System RNs (193 RNs) provide direct care and population-based services in the many counties in Texas that have no local health department, or where state support is needed.[198] These RNs are often the individuals who are on the frontline in the delivery of public health services to rural communities throughout the state, serving as consultants and advisors to county, local and stakeholder groups, and educating community partners. They assist in communicable disease

[193] HHSAS Database, as of 8/31/15.
[194] Ibid.
[195] Ibid.
[196] HHSAS Database, FY 2015 data.
[197] HHSAS Database, as of 8/31/15.
[198] Includes RN II - Vs in public health roles and public health nurses. Note: Public health nurses are also registered nurses.

investigation, control and prevention, and are critical to successful public health preparedness and response throughout the state.

Public Health RNs have, on average, about eight years of state service, with an average age of about 50 years.[199]

While overall turnover for these RNs at 18 percent is at the same level as the state average rate, certain areas of Texas experienced higher turnover than others, including Health Service Regions the Lubbock area at about 30 percent and the Houston area at 35 percent.[200] [201]

These RN positions often remain open for about five months before being filled.[202]

Inspector General's Office (IG) Registered Nurses (RNs)

There are 80 RNs employed as Nurse IVs and Nurse Vs (about four percent of System RNs) within IG.[203]

These IG nurses conduct hospital and nursing facility medical investigations and reviews to determine the accuracy of data. They conduct investigations and examinations of alleged violations of laws, rules and regulations regarding fraud in Medicaid coding, and perform utilization reviews on Medicaid recipients in Medicaid approved hospitals to determine necessity of admission and the accuracy of diagnosis and procedural coding. Employees in this classification also conduct Long Term Care Minimum Data Set (MDS) assessment reviews in Medicaid approved nursing facilities to determine the accuracy of assessment data provided by the nursing facility to ensure accurate payment.

IG nurse reviewers require at least one full year of training to be independent to conduct both hospital and nursing facility reviews.

The typical IG nurse is about 53 years old and has an average of approximately seven years of state service.[204]

The turnover rate for IG nurses is considered high at about 20 percent.[205]

Recruitment and retention of these RNs remains one of the most critical issues for IG due to extensive travel requirements and salary constraints.

[199] HHSAS Database, as of 8/31/15.
[200] HHSAS Database, FY 2015 data.
[201] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[202] HHSAS Database, as of 8/31/15.
[203] Ibid.
[204] Ibid.
[205] HHSAS Database, FY 2015 data.

The high turnover of most qualified staff has shown an increasing tendency to leave HHS to accept higher paying jobs in the public and private sector. This situation is expected become more urgent over time, since 35 percent of these highly skilled employees will be eligible to retire from state employment in the next five years.[206]

Licensed Vocational Nurses (LVNs)

There are about 1,024 direct care workers employed by HHS. The majority of these employees (about 99 percent) work at state hospitals and state supported living centers across Texas.[207]

About one percent work in Health Services Regions and central office program support, assisting in communicable disease prevention and control and the delivery of population-based services to individuals, families, and communities.

On average, a System LVN is 45 years old and has eight years of state service.[208]

As with RNs, the nursing shortage is also impacting the HHS' ability to attract and retain LVNs. Turnover for LVNs is currently very high at about 35 percent.[209]

Currently, the average annual salary for System LVNs during fiscal year 2015 was $36,766.[210] This salary falls below both national and state averages for this occupation. Nationally, the average annual earnings for licensed practical nurses and LVNs was $44,030, and $45,130 in Texas.[211] The State Auditor's Office 2014 market index analysis found the average state salary for LVN IIs was 10 percent behind the market rate.[212]

To address these difficulties, the 84th Legislature approved a targeted wage increase for LVNs in localities with the highest turnover rates. In addition, HHS may consider increasing entry-level salaries for new LVNs and for currently employed staff during fiscal years 2018 and 2019.

[206] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[207] Includes Licensed Vocational Nurse II and III.
[208] HHSAS Database, as of 8/31/15.
[209] HHSAS Database, FY 2015 data.
[210] HHSAS Database, as of 8/31/15.
[211] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 4/29/16.
[212] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.

LVNs at State Supported Living Centers

There are 534 LVNs employed at HHS state supported living centers across Texas. These LVNs are, on average, 45 years old and have an average of approximately eight years of state service.[213]

Turnover for LVNs at state supported living centers is one of the highest in the System at about 40 percent. Centers experienced the loss of 250 LVNs last fiscal year. Turnover is extremely high at the San Angelo State Supported Living Center (at 62 percent) and the El Paso State Supported Living Center (at 52 percent).[214]

With a very high vacancy rate of about 27 percent, vacant positions often go unfilled nearly six months. Some centers are experiencing even longer vacancy durations. At the Lufkin State Supported Living Center it takes about seven months to fill a position, while at the San Angelo State Supported Living Center, it takes over nine months.[215]

LVNs at State Hospitals

There are approximately 480 LVNs employed at HHS state hospitals ad centers across Texas.[216]

On average, a state hospital LVN is about 44 years old and has eight years of state service.[217]

Turnover for these LVNs is currently very high at about 30 percent. Turnover is especially high at the Waco Center for Youth, at 67 percent and the San Antonio State Hospital (at 44 percent).[218]

Many LVNs come into the state hospital system with limited training in caring for psychiatric patients. HHS state hospitals invest in employee training to ensure the highest quality of nursing care. The high turnover for LVN positions has a direct impact on the training resources dedicated to this occupational group. Decreasing turnover levels will significantly reduce the amount of time spent on training new employees.

LVNs in Public Health Roles

About one percent of System LVNs (10 LVNs) work in Health Services Regions across Texas. They have, on average, about 10 years of state service, with an average age of about 48 years.[219]

[213] HHSAS Database, as of 8/31/15.
[214] HHSAS Database, FY 2015 data.
[215] HHSAS Database, as of 8/31/15.
[216] Ibid.
[217] Ibid.
[218] HHSAS Database, FY 2015 data.
[219] HHSAS Database, as of 8/31/15.

The overall turnover for these LVNs is high at 20 percent.[220] Retention is expected to remain an issue as these employees approach retirement. Twenty percent of these tenured and skilled employees will be eligible to retire in the next five years.[221]

Nurse Practitioners and Physician Assistants

Under the supervision of a physician, 49 System nurse practitioners and physician assistants are responsible for providing advanced medical services and clinical care to individuals at state hospitals and those who reside in state supported living centers across Texas.[222]

These highly skilled employees have, on average, about 11 years of state service, with an average age of 52. Over 40 percent of these employees have more than 10 years of state service.[223]

System nurse practitioners and physician assistants earn an average annual salary of $106,250.[224] This salary falls slightly below the market rate. The State Auditor's Office 2014 market index analysis found the average state salary for Nurse Practitioners to be eight percent behind the market rate and Physician Assistants were four percent behind the market rate.[225]

Though the turnover for nurse practitioners and physician assistants is currently well managed at about 12 percent, the vacancy rate is high at 14 percent, with positions remaining vacant for an average of about five months.[226] [227]

Over 20 percent of nurse practitioners and physician assistants are currently eligible to retire, with this number increasing to 33 percent in the next five years. HHS will need to develop creative recruitment strategies to replace these highly skilled and tenured employees.[228]

[220] HHSAS Database, FY 2015 data.
[221] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[222] Ibid.
[223] Ibid.
[224] HHSAS Database, as of 8/31/15.
[225] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[226] HHSAS Database, FY 2015 data.
[227] HHSAS Database, as of 8/31/15.
[228] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.

Nurse Practitioners and Physician Assistants at State Supported Living Centers

HHS employs 13 nurse practitioners and physician assistants at state supported living centers across Texas, while the majority of the employees (85 percent) are nurse practitioners.[229]

These highly skilled employees have, on average, about eight years of state service, with an average age of 54.[230]

Turnover for these nurse practitioners and physician assistants is slightly below the state average of 18 percent at 15 percent.[231] [232]

With a high vacancy rate of 24 percent, vacant positions at state supported living centers go unfilled for months.[233]

Due to the continuing short supply and high demand for these professionals, HHS will need to develop creative recruitment strategies to replace these employees.

Nurse Practitioners and Physician Assistants at State Hospitals

HHS employs 36 nurse practitioners and physician assistants at state hospitals across Texas. The majority of these individuals (83 percent) are employed as nurse practitioners.[234]

These highly skilled employees have, on average, about 13 years of state service, with an average age of 51.[235]

Though turnover for these state hospital employees is currently low at about 11 percent, positions are often remaining unfilled for over four months before being filled.[236] [237]

About 22 percent of these highly skilled employees are currently eligible to retire. This number will increase to 33 percent in the next five years, making recruitment and retention for these jobs an ongoing challenge for the System.[238]

[229] HHSAS Database, as of 8/31/15.
[230] Ibid.
[231] HHSAS Database, FY 2015 data.
[232] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[233] HHSAS Database, as of 8/31/15.
[234] Ibid.
[235] Ibid.
[236] HHSAS Database, FY 2015 data.
[237] HHSAS Database, as of 8/31/15.
[238] Ibid.

Pharmacists

With about 297,000 active pharmacists as of May 2014, pharmacists represent one of the largest health professional groups in the U.S. While the overall supply of pharmacists has increased in the past decade, there has been an unprecedented demand for pharmacists and for pharmaceutical care services. Employment of pharmacists is projected to grow three percent from 2014 to 2024, slower than the average for all occupations. Increased demand for prescription medications is expected to lead to more demand for pharmaceutical services.[239]

HHS employs 95 pharmacists, with an average annual salary of $102,979.[240] This salary falls significantly below the market rate. The average annual salary for pharmacists nationally is $119,270 and $120,480 in Texas.[241] In addition, the State Auditor's Office 2014 market index analysis found the average state salary for Pharmacist Is to be 14 percent behind the market rate.[242] This disparity is affecting the System's ability to recruit qualified applicants for open positions. Pharmacist positions often remain unfilled for over six months.[243]

With pharmacist turnover high at about 20 percent, HHS has often contracted with pharmacists to meet program needs.[244] These contracted pharmacists are paid at rates that are well above the amount it would cost to hire pharmacists at state salaries. With a significant number of pharmacists nearing retirement age (or have already retired and returned to work), recruitment and retention will continue to be a problem for the System.

Pharmacists at State Supported Living Centers

About half of System pharmacists (40 employees) work at HHS state supported living centers. The typical pharmacist at these facilities is about 45 years old and has an average of seven years of state service.[245]

Turnover for these pharmacists is currently high at about 23 percent, with pharmacist positions often remaining unfilled for about six months before being filled. Some of these facilities are experiencing even longer vacancy durations. At the Abilene State Supported Living Center a pharmacist position has remained vacant

[239] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, web page http://www.bls.gov/ooh/healthcare/pharmacists.htm, last accessed on 5/2/16.
[240] HHSAS Database, as of 8/31/15.
[241] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 5/2/16.
[242] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[243] HHSAS Database, as of 8/31/15.
[244] HHSAS Database, FY 2015 data.
[245] HHSAS Database, as of 8/31/15.

for over a year, while at the Corpus Christi State Supported Living Center, positions remain vacant for nearly six months.[246]

HHS may face significant recruitment challenges in the next few years to replace these highly skilled employees who will be eligible for retirement. Though only five percent of these employees are currently eligible to retire, a quarter of them will be eligible in the next five years.[247]

Pharmacists at State Hospitals

There are 32 System pharmacists working in state hospitals across Texas. These highly skilled employees are essential to the timely filling of prescribed medications for patients in state hospitals. The majority of these employees are in Pharmacist II positions (28 employees or 88 percent).[248]

These pharmacists play a key role in the monitoring of costs and inventory of medications, and in the ongoing monitoring of in-patients' medication histories, needs and potential adverse drug issues. They provide important clinical consultation to psychiatrists and physicians regarding complex medical and psychiatric conditions that may be intractable to traditional medication treatment interventions.

The typical pharmacist at a state hospital is about 48 years old and has an average of 12 years of state service. About 44 percent of these employees have 10 or more years of service.[249]

Though turnover for these pharmacists is currently low at about 12 percent, positions are often remaining unfilled for nearly eight months before being filled. Some state hospitals are experiencing even longer vacancy durations. At the San Antonio State Hospital, a pharmacist position has remained vacant for over a year, while at the Terrell State Hospital, positions remain vacant for nearly six months.[250] [251]

With 22 percent of these pharmacists currently eligible to retire, and 38 percent eligible to retire in the next five years, HHS will need to develop creative recruitment strategies to replace these skilled and highly tenured employees.[252] To address these difficulties, HHS may consider increasing entry-level salaries for pharmacists and for currently employed state hospital pharmacists during fiscal years 2018 and 2019.

[246] HHSAS Database, as of 8/31/15.
[247] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[248] HHSAS Database, as of 8/31/15.
[249] Ibid.
[250] HHSAS Database, FY 2015 data.
[251] HHSAS Database, as of 8/31/15.
[252] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.

Dentists

The demand for dentists nationwide is expected to increase as the overall population grows. Employment of dentists is projected to grow by 18 percent through 2024.[253]

There are 28 dentists employed in HHS state supported living centers, state hospitals, and across the state in public health roles.[254]

Turnover for System dentists is very high, at 32 percent.[255]

One reason for this high turnover is the large disparity between private sector and HHS salaries. System dentists earn an average annual salary of $126,846.[256] This salary falls significantly below the market rate. The average annual salary for dentists nationally is $172,350 and $171,870 in Texas.[257] This disparity is also affecting the System's ability to recruit qualified applicants for open positions. Dentist positions often remain unfilled for several months.[258]

In addition, since most dentists do not have the experience or interest to work with the challenging special patient populations, HHS continues to experience difficulty recruiting and attracting qualified dentists at the starting salary levels offered.

These problems are expected to worsen as employees approach retirement. While 14 percent of these highly skilled employees are currently eligible to retire, this number will increase to 32 percent in the next five years.[259]

Dentists at State Supported Living Centers

Over half of System dentists (61 percent) provide advanced dental care and treatment for individuals living at the HHS supported living centers across Texas. The typical pharmacist at these facilities is about 53 years old and has an average of nine years of state service.[260]

Turnover for these dentists is currently high at about 23 percent, with dentist positions often remaining unfilled for an average of four months before being filled. At the Brenham State Supported Living Center, dentist positions remain vacant for over six months.[261] [262]

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[253] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, web page http://www.bls.gov/ooh/healthcare/dentists.htm, last accessed on 5/2/16.
[254] HHSAS Database, as of 8/31/15.
[255] HHSAS Database, FY 2015 data.
[256] HHSAS Database, as of 8/31/15.
[257] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 5/2/16.
[258] HHSAS Database, as of 8/31/15.
[259] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[260] HHSAS Database, as of 8/31/15.
[261] HHSAS Database, FY 2015 data.
[262] HHSAS Database, as of 8/31/15.

HHS may face significant recruitment challenges in the next few years to replace these highly skilled employees who will be eligible for retirement. About 18 percent of these employees are currently eligible to retire, and this number will increase to nearly 30 percent in the next five years.[263]

Dentists at State Hospitals and in Public Health Roles

HHS employs three dentists in state hospitals, providing preventive care, emergency dental interventions and other treatment services to patients. Another five dentists perform public heath roles are Central Office staff or members of five regional dental teams who conduct dental surveillance, data collection and reporting and provide preventive oral health services. Services are provided primarily to low-income, pre-school and school-age children in rural areas with limited or no access to these services.[264]

These dentists are, on average, about 46 years old, with an average of about seven years of state service.[265]

Turnover for these dentist positions is very high at about 46 percent.[266]

Though only 13 percent of these dentists are currently eligible to retire, 38 percent will be eligible to retire in the next five years. HHS will need to develop creative recruitment strategies to replace these highly skilled employees.[267]

Physicians

There are currently about 347,200 active physicians and surgeons across the country. Due to the increased demand for healthcare services by the growing and aging population, employment of physicians is projected to grow about 15 percent from 2014 to 2024, faster than the average for all occupations.[268] [269]

HHS employs 86 physicians, with majority (93 percent) employed in HHS state supported living centers, state hospitals and in Health Service Regions.[270]

[263] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[264] HHSAS Database, as of 8/31/15.
[265] Ibid.
[266] HHSAS Database, FY 2015 data.
[267] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[268] U.S. Department of Labor, Bureau of Labor Statistics, Selected Occupational Projections Data, web page http://data.bls.gov/projections/occupationProj, Period: May 2014; last accessed on 4/25/16.
[269] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, web page http://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm, last accessed on 5/2/16.
[270] HHSAS Database, as of 8/31/15.

These highly skilled employees have, on average, about 12 years of state service, with an average age of 59. Over 40 percent of these employees have more than 10 years of state service.[271]

System physicians are currently earning an average annual salary of $180,529.[272] This salary is below the average wage paid nationally ($197,700), and also lower than the Texas average of $197,410.[273]

Turnover for these physicians is currently high at 22 percent. In addition, the vacancy rate is very high at 19 percent, with positions remaining vacant for an average of about seven months.[274] [275]

About 38 percent of these highly skilled and tenured employees are currently eligible to retire, with this number increasing to 52 percent in the next five years.[276]

To address these difficulties, HHS may consider increasing entry-level salaries for physicians and for currently employed physicians during fiscal years 2018 and 2019.

Physicians at State Supported Living Centers

There are 39 physicians working at state supported living centers across Texas.[277] Full staffing of these positions is critical to direct-care services.

These physicians have, on average, about nine years of state service, with an average age of 57. Local physicians who have established long term private practices often apply as a staff physician at state supported living centers late in their working career to secure retirement and insurance benefits, thus explaining the reason for the high average age. Only two full-time physicians are under 40 years of age.[278]

Turnover for these physicians is considered high at 24 percent.[279]

To deal with these recruitment and retention difficulties, HHS has often used contract physicians to provide required coverage. These contracted physicians are paid at rates that are well above the amount it would cost to hire physicians at state salaries (costing in excess of $200 per hour, compared to the hourly rate of about

[271] HHSAS Database, as of 8/31/15.
[272] HHSAS Database, as of 8/31/15.
[273] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 5/2/16.
[274] HHSAS Database, FY 2015 data.
[275] HHSAS Database, as of 8/31/15.
[276] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[277] HHSAS Database, as of 8/31/15.
[278] Ibid.
[279] HHSAS Database, FY 2015 data.

$94 paid to physicians at state supported living centers).[280] Aside from being more costly, the System has experienced other problems with contracted physicians, including a lengthy learning curve, difficulty in obtaining long-term commitments, excessive staff time spent procuring their services, difficulty in obtaining coverage, dependability and inconsistency of services due to their short-term commitment.

To meet the health needs of individuals residing in state supported living centers, it is critical that HHS recruit and retain qualified physicians. However, due to the short supply and large demand, state supported living centers are experiencing difficulty hiring physicians. With a high vacancy rate of 17 percent, positions are remaining unfilled for an average of five months.[281]

Physicians at State Hospitals

There are currently 30 physicians at HHS who are providing essential medical care in state hospitals.[282] They take the lead role in diagnosing, determining a course of treatment, making referrals to outside medical hospitals, prescribing medications and monitoring the patients' progress toward discharge. Physician services in state hospitals are essential to the ongoing monitoring and management of an increasing number of complex chronic medical conditions, such as diabetes, seizure disorders, hypertension and chronic obstructive pulmonary disease (COPD). These employees are critical to the System's preparedness and response to medical services provided by the state and to major public health initiatives, such as obesity prevention, diabetes, disease outbreak control and others.

These physicians have, on average, about 16 years of state service, with an average age of about 63. Local physicians who have established long term private practices often apply as physicians at state hospitals late in their working career to secure retirement and insurance benefits, contributing to the high overall age. Only 12 full-time physicians are under 50 years of age.[283]

Turnover for these physicians is currently high at 23 percent.[284]

With a very high vacancy rate of about 27 percent, it takes about nine months to fill a state hospital physician position with someone who has appropriate skills and expertise.[285]

In addition, HHS may face significant challenges in the next few years to replace those employees who are eligible for retirement. About 57 percent of these highly skilled and tenured employees are currently eligible to retire. Within five years,

[280] HHSAS Database, as of 8/31/15.
[281] Ibid.
[282] HHSAS Database, FY 2015 data.
[283] HHSAS Database, as of 8/31/15.
[284] HHSAS Database, FY 2015 data.
[285] Ibid.

nearly 67 percent will be eligible to retire. If these employees choose to retire, the HHS would lose some of the most experienced medical personnel – those with institutional knowledge and skills that will be difficult to match and even harder to recruit.[286]

Recruitment of qualified candidates, as well as retention of these highly skilled and knowledgeable employees, continues to be a challenge for the System.

Compensation levels will need to be increased to effectively compete in a market where qualified applicants are in short supply and healthcare competitors offer a higher starting salary. The cost of obtaining clinical staff through a placement service or contract far exceeds the cost of hiring and retaining an agency physician. Attracting and keeping clinical staff that are trained in the use of HHS electronic equipment and clinical practices, as well as familiarity with the consumer population, is more productive and cost-effective.

Physicians in Public Health Roles

There are 11 HHS physicians performing public health services.[287] Physicians serving in public health roles in Health Service Regions and Central Office act as state and regional consultants and advisors to county, local, hospital, and stakeholder groups, and provide subject matter expertise on programs and services. These physicians provide public health services that are essential to the provision of direct clinical services in areas of the state where local jurisdictions do not provide services in communicable disease control and prevention and population-based services.

Physicians serving in Health Service Regions initiate treatment of communicable diseases; refer, prescribe medication, and monitor treatment. They oversee infectious disease investigation, control, and prevention efforts regionally, and provide direction for public health preparedness and response centrally and in the Health Service Regions. Some of the physicians who serve as Regional Directors are required by statute to also serve as the Local Health Authority (LHA) in counties that do not have a designated LHA. As such, they enforce laws relating to public health; establish, maintain and enforce quarantines; and report the presence of contagious, infectious, and dangerous epidemic diseases in the health authority's jurisdiction. As Regional Medical Directors, physicians in Health Service Regions serve as community leaders and conveyors of health-related organizations and individuals for the purpose of improving the health of all Texans.

These physicians are, on average, about 52 years old, with an average of about 11 years of state service.[288]

[286] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[287] HHSAS Database, as of 8/31/15.
[288] Ibid.

Turnover for these positions is high at about 24 percent.[289]

Vacancies in Regional Medical Director (RMD) positions are extremely difficult to fill, especially in major metropolitan and border regions. One RMD vacancy in the Houston area took over three years to fill. RMD positions in the Tyler and Harlingen area have been vacant for 15 months.

Currently, 27 percent of these physicians are eligible to retire, with the number employees eligible to retire increasing to over 60 percent in the next five years. HHS will need to develop creative recruitment strategies to replace these highly skilled employees.[290]

Psychiatrists

There are currently about 28,000 psychiatrists nationwide. Increased demand for healthcare services by the growing and aging population is expected to result in a 15 percent rate of growth from 2014 to 2024.[291]

HHS employs 130 psychiatrists in HHS state supported living centers and state hospitals, with the majority of these psychiatrists (about 88 percent) employed in state hospitals across Texas.[292]

These highly skilled and tenured employees have, on average, about 12 years of state service, with an average age of 54.[293]

System psychiatrists currently earn an average annual salary of $218,777.[294] The State Auditor's Office 2014 market index analysis found the average state salary for Psychiatrist IIs to be six percent behind the market rate.[295]

Turnover for System psychiatrists is currently high at about 22 percent. In addition, the vacancy rate is very high at about 18 percent, with positions remaining vacant for an average of about eight months.[296] [297]

[289] HHSAS Database, FY 2015 data.
[290] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[291] U.S. Department of Labor, Bureau of Labor Statistics, Selected Occupational Projections Data, web page http://data.bls.gov/projections/occupationProj, Period: May 2014; last accessed on 4/25/16.
[292] HHSAS Database, as of 8/31/15.
[293] Ibid.
[294] Ibid.
[295] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16. Note: Since these were no Auditor IIs in IG, data on the market rate for this classification was not included.
[296] HHSAS Database, FY 2015 data.
[297] HHSAS Database, as of 8/31/15.

About 30 percent of these highly skilled and tenured employees are currently eligible to retire, with this number increasing to 44 percent in the next five years.[298]

To address these difficulties, HHS may consider increasing entry-level salaries for psychiatrists and for currently employed psychiatrists during fiscal years 2018 and 2019.

Psychiatrists at State Supported Living Centers

The 15 psychiatrists assigned to state supported living centers are in senior-level Psychiatrist III positions. Full staffing of these positions is critical to providing psychiatric services needed by residents.[299]

These psychiatrists have, on average, about eight years of state service, with an average age of 56.[300]

Turnover for these psychiatrists is very high at 39 percent.[301]

With a very high vacancy rate of 40 percent, vacant positions in state supported living centers go unfilled for over 10 months.[302] In fact, many of the postings and advertisements for these positions result in no responses from qualified applicants.

To deal with these recruitment and retention difficulties, HHS has often used contract psychiatrists to provide required coverage. These contracted psychiatrists are paid at rates that are well above the amount it would cost to hire psychiatrists at state salaries (costing in excess of $200 per hour, compared to the hourly rate of about $105 paid to System psychiatrists at state supported living centers).[303] Aside from being more costly, HHS has experienced other problems with contracted psychiatrists, including a lengthy learning curve, difficulty in obtaining long-term commitments, excessive staff time spent procuring their services, difficulty in obtaining coverage, dependability and inconsistency of services due to their short-term commitment.

To meet the health needs of individuals residing in state supported living centers, it is critical that HHS fill all budgeted psychiatrist positions and effectively recruit and retain qualified psychiatrists.

[298] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[299] HHSAS Database, as of 8/31/15.
[300] Ibid.
[301] HHSAS Database, FY 2015 data.
[302] HHSAS Database, as of 8/31/15.
[303] Ibid.

Psychiatrists at State Hospitals

There are currently 115 System psychiatrists providing essential medical and psychiatric care in state hospitals.[304] These highly skilled employees take the lead role in diagnosing, determining a course of treatment, prescribing medications and monitoring patient progress.

These psychiatrists have, on average, about 13 years of state service, with an average age of 53. About 53 percent of these employees have 10 or more years of service.[305]

Annual turnover for these psychiatrists is currently high at about 20 percent. Big Springs State Hospital reported the highest state hospital turnover rate of 57 percent.[306]

With a high vacancy rate of about 14 percent, most vacant psychiatrist positions go unfilled for months.[307] At some state hospitals, these positions remain vacant for seven months (at the Rusk and Terrell state hospitals). These challenges are expected to continue, as more than 30 percent of these highly skilled and tenured employees are currently eligible to retire, and may leave at any time. Within five years, this number will increase to 46 percent.[308]

State hospitals face increasing difficulty in recruiting qualified psychiatrists. This has resulted in excessively high workloads for the psychiatrists on staff, reducing the ability of state hospitals to function at full capacity, placing hospital accreditation at risk and increasing the average length of patients' stay.

To deal with these recruitment difficulties, the System has often used contract psychiatrists to provide required coverage. These contracted psychiatrists are paid at rates that are well above the amount it would cost to hire psychiatrists at state salaries (costing in excess of $200 per hour, compared to the hourly rate of about $105 paid to psychiatrists at state hospitals).[309] These contracted psychiatrists may not be immediately available in an emergency (increasing the risk to patients) and are unable to provide the individualized treatment that arises from daily contact with staff and patients. Consequently, the patient’s length of stay increases and annual number of patients served decreases. Since medical records of patients are almost completely electronic, psychiatrists are required to be proficient at computer entry and documentation. It often takes many weeks to train a contract psychiatrist on the nuances of the electronic medical record system.

[304] HHSAS Database, as of 8/31/15.
[305] Ibid.
[306] HHSAS Database, FY 2015 data.
[307] HHSAS Database, as of 8/31/15.
[308] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[309] HHSAS Database, as of 8/31/15.

Due to the complex medical and mental challenges that individuals residing in state hospitals exhibit, it is critical that HHS is able to effectively recruit and retain qualified psychiatrists. Continued targeted recruitment strategies and retention initiatives for these highly skilled professionals must be ongoing.

Psychologists

There are 236 psychologists in HHS, with the majority (98 percent) employed in state supported living centers and state hospitals across the state.[310]

System psychologists earn an average annual salary of $57,043.[311] This salary falls below the market rate. The State Auditor's Office 2014 market index analysis found the average state salary for Psychologist IIs to be nine percent behind the market rate.[312]

Turnover for these psychologists is high at 25 percent, with psychologist positions often remaining unfilled for several months before being filled.[313] [314]

Psychologists at State Supported Living Centers

About 77 percent of HHS psychologists (182 employees) work at state supported living centers across Texas. These employees participate in quality assurance and quality enhancement activities related to the provision of psychological and behavioral services to state supported living center residents; provide consultation and technical assistance to individuals with cognitive, developmental, physical and health related needs; implement and evaluate behavioral support plans; review the use of psychotropic medication in treating behavior problems; perform chart reviews; and perform observations and assessments relevant to the design of positive interventions and supports for individuals.[315]

The typical psychologist at these facilities is about 41 years old and has an average of eight years of state service.[316]

Turnover for these psychologists is high at about 26 percent, reflecting the loss of about 52 workers during fiscal year 2015. Turnover rates by location ranged from 10

[310] HHSAS Database, as of 8/31/15. Note: Includes Psychologists, Behavioral Health Specialists, and Behavioral Analysts.
[311] HHSAS Database, as of 8/31/15.
[312] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[313] HHSAS Database, FY 2015 data.
[314] HHSAS Database, as of 8/31/15.
[315] Ibid.
[316] Ibid.

percent at the Denton State Supported Living Center to 75 percent at the El Paso State Supported Living Center.[317]

With a high vacancy rate for these positions (at approximately 11 percent), psychologist positions often remain open for months before being filled. At the Brenham State Supported Living Center, positions have remained vacant for an average of 10 months.[318]

Psychologists at State Hospitals

There are 50 psychologists working at HHS state hospitals, with nearly 60 percent employed in Psychologist II positions.[319] Full staffing of these positions is critical to providing needed psychological services to patients.

These psychologists play a key role in the development of treatment programs for both individual patients and groups of patients. Their evaluations are critical to the ongoing management and discharge of patients receiving competency restoration services, an ever growing patient population in the state hospitals. They also provide testing and evaluation services important to ongoing treatment, such as the administration of IQ, mood, and neurological testing instruments.

These highly skilled and tenured employees have, on average, about 10 years of state service, with an average age of 46.[320]

Turnover for these psychologists is high at about 22 percent. The San Antonio State Hospital experienced the highest turnover at 43 percent.[321]

The vacancy rate for these positions is very high, at about 18 percent, with positions often remaining unfilled for over seven months.[322]

HHS may face significant recruitment challenges in the next few years, as 18 percent of these highly skilled and tenured employees are currently eligible for retirement, and may leave HHS at any time.[323]

It is critical that the HHS fill all budgeted state hospital psychologist positions and is able to effectively recruit and retain qualified psychologists.

[317] HHSAS Database, FY 2015 data.
[318] HHSAS Database, as of 8/31/15.
[319] Ibid.
[320] Ibid.
[321] HHSAS Database, FY 2015 data.
[322] HHSAS Database, as of 8/31/15.
[323] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.

Epidemiologists

HHS employs 91 full-time epidemiologists who provide services in the areas of infectious disease and injury control, chronic disease control, emergency and disaster preparedness, disease surveillance and other public health areas.[324] They provide critical functions during disasters and pandemics and other preparedness and response planning.

Nationally, there is a shortage of epidemiologists.[325] [326] Although epidemiology is known as the core science of public health, epidemiologists comprise less than one percent of all public health professionals.[327] As of May 2014, there were approximately 5,800 epidemiologist jobs in the U.S., with a projected job growth rate of 6.3 percent by 2022.[328]

On average, System epidemiologists have about nine years of state service, with an average age of approximately 39 years.[329]

Turnover for System epidemiologists is currently high, at about 25 percent, well above the state average turnover rate of 18 percent. This rate is much higher for entry-level Epidemiologist Is, at 38 percent. When the level of on-the-job experience needed to adequately perform the job is considered, this high turnover rate is of special concern. It takes, on average, a year for a new epidemiologist to learn his or her job. Several years are required to develop the specialized expertise required of senior epidemiologists to support the state and protect public health.[330] [331]

HHS is currently experiencing difficulty filling vacant epidemiologist positions. Vacant positions are going unfilled for many months due to a shortage of qualified applicants available for work.[332]

Low pay is a contributing factor in the inability to attract qualified epidemiologist applicants. System epidemiologists are currently earning an average annual salary

[324] HHSAS Database, as of 8/31/15.
[325] "2007 State Public Health Workforce Survey Results," The Association of State and Territorial Health Officials, web page http://biotech.law.lsu.edu/cdc/astho/WorkforceReport.pdf, last accessed on 4/29/16.
[326] Patricia A. Drehobl, Sandra W. Roush, Beth H. Stover, and Denise Koo, "Public Health Surveillance Workforce of the Future" Morbidity and Mortality Weekly Report (MMWR), 61(03); 25-29 (July 2012), web page http://www.cdc.gov/mmwr/pdf/other/su6103.pdf, last accessed on 5/9/14.
[327] Melissa Taylor Bell and Irakli Khodeli. "Public Health Worker Shortages," The Council of State Governments, November 2004.
[328] U.S. Department of Labor, Bureau of Labor Statistics, Selected Occupational Projections Data, web page http://data.bls.gov/projections/occupationProj, Period: May 2014; last accessed on 4/20/16.
[329] HHSAS Database, as of 8/31/15.
[330] HHSAS Database, FY 2015 data.
[331] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[332] HHSAS Database, as of 8/31/15.

of $56,861.[333] This salary is significantly below the average wage paid nationally ($76,900), and also lower than the Texas average of $66,880.[334]

In addition, HHS may face significant recruitment challenges in the next few years to replace these highly skilled employees who are eligible for retirement. Though only 11 percent of these employees are currently eligible to retire, this rate will increase in the next five years to 23 percent.[335]

HHS will need to closely monitor this occupation due to the nationally non-competitive salaries and a general shortage of professionals performing this work.

Sanitarians

Another public health profession currently experiencing shortages is environmental health workers (i.e., sanitarians).[336] [337]

There are 127 sanitarians employed with HHS.[338] HHS registered sanitarians inspect all food manufacturers, wholesale food distributors, food salvagers in Texas, as well as all retail establishments in the 188 counties not covered by local health jurisdictions and conduct a multitude of environmental inspections such as children's camps, asbestos abatement, hazardous chemicals/products and many others. Sanitarians are instrumental in protecting the citizens of Texas from food-borne illness and many dangerous environmental situations and consumer products, including imported foods, drugs and consumer products. The U.S. Food and Drug Administration (FDA) and the Consumer Products Safety Commission (CPSC) have little manpower and therefore depend on the state programs to protect citizens. System sanitarians also respond to a variety of emergencies, including truck wrecks, fires, tornados, floods and hurricanes. They are the first line of defense against a bioterrorist attack on the food supply.

On average, HHS sanitarians are 46 years old and have about 10 years of state service. About 43 percent of these employees have 10 or more years of state service.[339]

[333] HHSAS Database, as of 8/31/15.
[334] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 4/20/16.
[335] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[336] "2007 State Public Health Workforce Survey Results," The Association of State and Territorial Health Officials, web page http://biotech.law.lsu.edu/cdc/astho/WorkforceReport.pdf, last accessed on 4/21/16.
[337] Patricia A. Drehobl, Sandra W. Roush, Beth H. Stover, and Denise Koo, "Public Health Surveillance Workforce of the Future" Morbidity and Mortality Weekly Report (MMWR), 61(03); 25-29 (July 2012), web page http://www.cdc.gov/mmwr/pdf/other/su6103.pdf, last accessed on 5/9/14.
[338] HHSAS Database, as of 8/31/15.
[339] Ibid.

Though the turnover rate for HHS sanitarians is currently low at about 10 percent, HHS has experienced difficulty filling vacant positions, with vacant positions often going unfilled for many months due to a shortage of qualified applicants available for work.[340] [341]

Historically, HHS has faced special challenges filling vacancies in both rural and urban areas of the state. In addition, the state requirement for sanitarians to be registered and have at least 30 semester hours of science (in addition to 18 hours of continuing education units annually) has made it increasingly difficult to find qualified individuals.

With 17 percent of sanitarians currently eligible to retire, and 39 percent eligible to retire in the next five years, HHS will need to develop creative recruitment strategies to replace these skilled and highly tenured employees.[342]

Laboratory Staff

HHS operates a state-of-the-art state laboratory in Austin and two regional laboratories, one in San Antonio and the other in Harlingen. The Austin State Hospital provides laboratory services for the other HHS state hospitals and state supported living centers.

While laboratory staff is made up of a number of highly skilled employees, there are four job groups that are essential to laboratory operations: chemists, microbiologists, laboratory technicians and medical technologists.

Targeted recruitment and retention strategies are used to ensure that HHS laboratories have enough staff to meet HHS goals. One strategy has been to contract with private laboratories. This has not been a particularly desirable alternative to hiring laboratory staff. Barriers to using contracts with private labs include securing a cost-effective contract arrangement and the difficulty in obtaining a long term commitment. In most cases, contracting with private lab services is more costly than hiring staff to perform these services. To further address these difficulties, HHS may consider increasing entry-level salaries for new laboratory staff and for currently employed staff during fiscal years 2018 and 2019.

[340] HHSAS Database, FY 2015 data.
[341] HHSAS Database, as of 8/31/15.
[342] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.

Chemists

There are 59 chemists employed in the HHS Division for Disease Control and Preventive Services, all located in Austin.[343]

The typical System chemist is about 47 years old and has an average of about 12 years of state service. Nearly half of the employees have 10 years or more of state service.[344]

While the overall turnover rate for System chemists is well managed at about 10 percent annually, Chemist IIs experienced a 19 percent turnover rate, slightly above the state average turnover rate of 18 percent.[345] [346]

The vacancy rate for System chemists is currently high at about 17 percent, with vacant positions often going unfilled for many months due to a shortage of qualified applicants available for work.[347] These vacancy problems are expected to worsen as employees approach retirement. Nearly 20 percent of these tenured and highly skilled employees are currently eligible to retire.[348]

Low pay is a factor in the inability to attract qualified chemist applicants. System chemists earn an average annual salary of about $45,940.[349] The State Auditor's Office 2014 market index analysis found the average state salary for chemists ranged from three to 11 percent behind the market rate.[350] The average annual salary for chemists nationally is $77,860 and $71,670 in Texas.[351]

Microbiologists

There are 130 microbiologists working for HHS, with the majority at the Austin laboratory.[352]

System microbiologists have, on average, about 11 years of state service, with an average age of about 41 years.[353]

[343] HHSAS Database, as of 8/31/15.
[344] Ibid.
[345] HHSAS Database, FY 2015 data.
[346] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[347] HHSAS Database, as of 8/31/15.
[348] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[349] HHSAS Database, as of 8/31/15.
[350] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[351] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 4/20/16.
[352] HHSAS Database, as of 8/31/15.
[353] Ibid.

The turnover rate for all System microbiologists is below the state average rate of 18 percent at about 14 percent. This rate is much higher for entry-level Microbiologist Is (at 26 percent) and Microbiologist IIs (at 21 percent).[354] [355]

System microbiologists earn an average annual salary of about $43,069.[356] The State Auditor's Office 2014 market index analysis found the average state salary for microbiologists ranged from one to seven percent behind the market rate.[357] This average annual salary also falls below the national and statewide market rates for this occupation. The average annual salary for microbiologists nationally is $76,230 and $55,100 in Texas.[358] This disparity in earnings is affecting the System's ability to recruit qualified applicants for open positions. Microbiologist positions often remain unfilled for several months.[359]

In addition, HHS may face significant recruitment challenges in the next few years to replace these highly skilled and tenured employees who are eligible for retirement. Though only 13 percent of these employees are currently eligible to retire, this rate will increase in the next five years to 25 percent.[360]

Laboratory Technicians

The laboratory technician profession is currently experiencing national shortages.[361]

There are 53 laboratory technicians employed at HHS.[362]

The typical laboratory technician is about 41 years old and has an average of 11 years of state service.[363]

The turnover rate for System laboratory technicians is slightly below the state average rate of 18 percent at about 16 percent.[364] [365]

[354] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[355] HHSAS Database, FY 2015 data.
[356] HHSAS Database, as of 8/31/15.
[357] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[358] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 4/21/16.
[359] HHSAS Database, as of 8/31/15.
[360] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[361] Bill Malone, "May 2011 Clinical Laboratory News: Trends in Recruitment and Retention" Clinical Laboratory News, 37(5) (May 2011).
[362] HHSAS Database, as of 8/31/15.
[363] Ibid.
[364] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[365] HHSAS Database, FY 2015 data.

The vacancy rate for System laboratory technicians is currently high at about 15 percent, with vacant positions often going unfilled for many months due to a shortage of qualified applicants available for work.[366]

Low pay is a factor in the inability to attract qualified laboratory technician applicants. HHS laboratory technicians earn an average annual salary of about $30,128.[367] The average annual salary for medical and clinical laboratory technicians nationally is $41,420 and $38,970 in Texas.[368] The State Auditor's Office 2014 market index analysis found the average state salary for laboratory technicians ranged from five percent above to 15 percent behind the market rate.[369]

These problems are expected to worsen as employees approach retirement. Nearly 30 percent of these tenured and highly skilled employees will be eligible to retire in the next five years.[370]

Medical Technologists

The medical technologist profession is also currently experiencing national shortages.[371]

Within HHS, there are 65 medical technologists.[372] These workers perform complex clinical laboratory work and are critical to providing efficient and quality healthcare.

System medical technologists have, on average, about 11 years of state service, with an average age of 44 years. About 45 percent of these employees have 10 or more years of state service.[373]

The turnover rate for all System medical technologists is slightly below the state average rate of 18 percent at about 16 percent. This rate is much higher for entry-level Medical Technologist Is (at 20 percent) and Medical Technologist IIs (at 34 percent).[374] [375]

[366] HHSAS Database, as of 8/31/15.
[367] Ibid.
[368] US Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 4/21/16.
[369] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[370] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.
[371] Bill Malone, "May 2011 Clinical Laboratory News: Trends in Recruitment and Retention" Clinical Laboratory News, 37(5) (May 2011).
[372] HHSAS Database, as of 8/31/15.
[373] Ibid.
[374] State Auditor's Office (SAO) FY 2015 Turnover Statistics.
[375] HHSAS Database, FY 2015 data.

The vacancy rate for System medical technologists is currently high at about 15 percent, with vacant positions often going unfilled for many months due to a shortage of qualified applicants available for work.[376]

HHS medical technologists earn an average annual salary of $41,993, which is below the average wage paid nationally ($61,860), and also lower than the Texas average of $59,660.[377] [378] In addition, the State Auditor's Office 2014 market index analysis found the average state salary for medical technologists ranged from seven to 16 percent behind the market rate.[379] This disparity is affecting the HHS' ability to recruit qualified applicants for open positions.

Though only 14 percent of these employees are currently eligible to retire, over a quarter of these employees will be eligible in the next five years. HHS will need to develop creative recruitment strategies to replace these highly skilled and tenured employees, and to ensure a qualified applicant pool is available to select from as vacancies occur.[380]

[376] HHSAS Database, as of 8/31/15.
[377] Ibid.
[378] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2015; last accessed on 4/21/16. Note: The Employees are listed under the Occupational title of Medical and Clinical Laboratory Technologists.
[379] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," September 2014, Report No. 15-701, web page http://www.sao.state.tx.us/reports/main/15-701.pdf, last accessed 4/21/16.
[380] Includes return-to-work retirees. HHSAS Database, as of 8/31/15.

DEVELOPMENT STRATEGIES TO MEET WORKFORCE NEEDS

Recruitment Strategies

General Strategies

- Increase attendance at job fairs, college fairs, and military installation recruiting events.
- Develop or enhance partnerships with entities such as, but not limited to, social service agencies, workforce centers, veteran networks, high schools, PAL programs and colleges or universities
- Market positions that qualify for participation in the federal Public Service Loan Forgiveness (PSLF) Program, which allows qualifying full-time employees to have the remaining balance of their Direct Loans forgiven after making 120 qualifying monthly payments.
- Promote the benefits of state employment, including job stability, insurance, career advancement ladder and opportunities, and the retirement pension plan.
- Develop LinkedIn pages promoting HHS as an employer of choice;
- Create HHS Jobs pages for passive recruitment;
- Develop active recruitment strategies for candidate sourcing via social media professional networks.

State Supported Living Center Strategies

- Continue to advertise employment opportunities using a variety of media sources, including print advertising in local and regional newspapers, billboards, and local radio and television commercials.
- Continue to post jobs on various employment and professional websites.
- Continue to use banners and billboard-style signage near the entrance of the facilities to advertise available positions.
- Continue to use of direct mail to increase awareness of job opportunities.
- Continue to participate in major job fairs.
- Continue to host on-campus job fairs for direct support professionals, nurses, and support positions such as Food Service, Housekeeping, and Maintenance, and management specialist/recruiter supports the facilities when requested by sending additional recruitment materials.
- Continue to attend career fairs targeting veterans in an effort to recruit the growing number of veterans leaving military service and seeking employment in other governmental entities.
- Continue to submit salary exception requests for approval of salary offers greater than the HHS allowable amount.
- Continue to adjust nurse salaries in Regions 6, 7 and 11 to be more competitive with the private sector.

- Continue to posting positions in multiple cities when possible and moved positions around to the different regions in an effort to recruit viable nurse applicants.
- Continue to inform nurse applicants of available incentives such as teleworking from home or offering compressed or flex schedules.
- Implement a nursing plan that provides promotional opportunities for nurses that want to remain in direct contact roles in addition to those seeking management opportunities.
- Hire J-1 Visa Waiver applicants. The J-1 Visa Waiver allows a foreign student who is subject to the two-year foreign residence requirement to remain in the U.S. upon completion of degree requirements/residency program, if they find an employer to sponsor them. The J-1 Visa Waiver applies to specialty occupations in which there is a shortage. The J-1 Waiver could be used to recruit physicians, pharmacists, psychiatrists, dentists, psychologists, nurse practitioners, physician assistants, registered therapists, and others for a minimum of three years.
- Request salary increases for physicians, nurse practitioners, and psychiatrists.

State Hospital and Public Health Strategies

- Continue using social work, nursing, medical student, psychiatric resident and other medical professional student/intern rotations at state hospitals, central office, and within Health Service Regions.
- Continue using internet-based job postings, billboards, job fairs, professional newsletters, list serves and recruitment firms.
- Continue posting difficult-to-recruit positions in professional publications.
- Continue regular and ongoing dialogues and presence with baccalaureate and advanced nursing program educators in Texas schools and respective universities in the state and surrounding areas;
- Solidify a “pipeline”
    - from academia to HHS for students to learn about the work of the System and gain experience, skills and qualifications through internships.
    - through ongoing public health nursing internships between nursing schools and HHS for students to learn about the work, and gain experience, skills and qualifications through practical experience.
- Work with nurse practitioner educational programs to develop, fund and promote specialty psychiatric nurse practitioner tracks with rotations in state hospitals.
- Offer incentives and educational leave to encourage System non-licensed staff in state hospitals and Health Service Regions to train to become RNs or other critical shortage staff.
- Review current sanitarian salaries from local health departments, industry and the federal government and make necessary salary adjustments.
- Enhance capacity to recruit bilingual workers.
- Provide additional workforce support and expertise in area of recruitment to work units.

- Consider the use of recruitment bonuses and moving allowances for highly competitive job categories, such as psychiatrists, pharmacists and other “shortage” clinical professionals.
- Fund stipends for Psychiatrists-in-Training at state hospitals.
- Request exception to HHS rules governing the hiring of licensed psychological personnel to include license-eligible applicants, with agreement that full licensing will be obtained within a certain time frame.

Other Targeted Strategies

- Department of Family and Protective Services (DFPS) Protective Service Worker Strategies:
    - Continue providing an internet resource. By clicking on the "Jobs" link from https://www.dfps.state.tx.us/, users are taken to the "Come Work for Us" page that includes realistic job preview videos for Adult Protective Services (APS), Child Care Licensing (CCL), Residential Licensing Services (RCCL) Specialists, and Child Protective Services (CPS) positions, as well as written realistic job previews for all of the programs. CPS also has a self-screening test that asks applicants questions to help them decide which stage of service might be a better fit for them prior to applying.
    - Continue using a pre-screening test for job applicants to assess skills and performance capabilities. DFPS implemented a new hiring process in March 2015 to focus screening efforts around identifying the best attributes needed to be successful as a direct delivery caseworker. The HSI is founded on research contained within A Research-Based Child Welfare Employee Selection Protocol6, and requires applicants to respond to a series of behavioral and skill assessment questions assessing risk in the following areas with a rating of Not A Strength (NAS), Adequate (ADQ), or Strong (STR):
        - Attendance / Turnover Risk
        - Conscientiousness
        - Demonstrates Respect
        - Self-Management
        - Service Orientation
        - Analytical Skills
        - Reading Comprehension
        - DFPS Math and Reasoning

      After evaluating applications and HSI responses, the TAG Hiring Specialist and Program Supervisors collaborate to select which applicants they wish to interview and hire.

To refine the new HSI model further, Workforce Development and The National Association of Social Workers - Texas (NASWTX) are working in partnership on the development of an external stakeholder survey focused on clients' perspectives of what makes a great caseworker. This survey will focus on case outcomes and ask those who received services from DFPS what caseworker behaviors or characteristics made their experience great. If proven successful, the long-term goal for this project would be to take a similar approach to all DFPS Program services, informing agency hiring practices across the spectrum of DFPS services.

- Continue efforts to recruit bilingual workers by using consistent testing for bilingual skills and implementing a consistent policy for bilingual pay.
- Allow for the substitution of CPS related experience in lieu of education for CPS services statewide
- Provide an increased starting salary (6.8 percent or 3.4 percent) to social work graduates hired into APS, CPS and State Wide Intake (SWI).
- Improve the recruitment of students in the Title IV-E Child Welfare Training Program, which will increase organizational loyalty among its graduates
- Explore the feasibility of hiring individuals with two-year degrees for qualifying protective services worker positions, along with creating a career path for those individuals for achieving long-term service with HHS.
- Initiate a 2-year degreed CPS caseworker pilot for hiring internal candidates with qualifying job experience (e.g., Human Services and Administrative Technicians).
- Expand statewide for all CPS stages of service the substitution of experience in lieu of education.
- Increase the marketing of the unique values associated with "Protecting the Unprotected."
- Provide the following focused recruitment activities for jobs with low applicant pools and high vacancy rates:
    - Offer 6.8 percent above base salary.
    - Provide locality pay in some areas of the state.
    - Provide recruitment bonuses to certain staff.
    - As funding allows, deploy recruiters in key areas of the state to build relationships and source potential applicants.
    - Attend job fairs and organize hiring fairs in specific areas to interview many staff in one or two days.
    - Partner with DFPS media specialists to produce special interest stories about jobs.
    - Add training sessions to accommodate all new hires.
    - Increase hiring specialist resources for targeted areas, when necessary.

        - Work with contracted partners to expedite certain hiring activities.

- Claims Examiners
    - Work with institutions of higher education in the Austin area to share Social Security Administration's (SSA's) training curriculum for Claims Examiners and explore interest with Department Heads and Professors for adding some of the SSA training concepts into their curriculum.

- Sanitarians
    - Continue facilitating the use of a "Sanitarian-In-Training" model, whereby individuals with appropriate education and experience but who lack the required license may be hired at a lower pay group in a related classification (as Environmental Protection Specialist Is) and provided the opportunity to obtain their license and supplement their field experience.

Retention Strategies

General Strategies

- Explore opportunities for flexible work schedules, telework, mobile work and alternative officing.
- Develop a management forum and other tools to assist individuals with the technical skills transition and be successful in positions that require both technical and management skills.
- Continue promoting succession planning/career development through HHS programs, such as the HHS Leadership Development Program.

State Supported Living Center Strategies

- Continue paying licensure fees and required training and continuing education costs for employees whose position require them to maintain professional licensure.
- SSLC Division has added a Licensed Vocational Nurse IV to the available positions. This provides ability to retain LVN's as their experience increases and also to offer higher salaries for more experienced applicants.

State Hospital and Public Health Strategies

- Continue involvement in HHS System-wide efforts to address health and human services workforce issues, including retention of staff filling essential positions and participation in leadership development opportunities.
- Continue to provide adequate training to assist employees in preparedness of their jobs and expand opportunities for cross-training.

- Continue to provide formally approved continuing education for various licensed healthcare professionals that meet requirements for credentialing and evaluate options for paying for these continuing education programs.
- Continue adjusting and approving Nursing Compensation plans every two years.
- Develop a methodology for performance-based merits.
- Improve the work environment through the provision of adequate technological tools, streamlined business processes and additional supervisory training.
- Provide additional workforce support and expertise in the area of retention to work units.
- Consider opportunities to mentor professional staff.
- Recognize and reward employees who make significant contributions.
- Increase System commitment to and effectiveness of retaining a racially and ethnically diverse workforce.
- Implement continuous business improvement processes.

Other Targeted Strategies

- Department of Family and Protective Services (DFPS) Protective Service Worker Strategies:
    - Partner with stakeholders to conduct a multi-phased benefits (i.e., salary) study that evaluates the System's competitiveness and pay strategies within the existing industry market.
    - Use applicable literature reviews, successful private sector initiatives, and internal statewide agency best practices to implement new or revise existing onboarding strategies.
    - Administer surveys and use the data to improve existing practices and guide the development of new initiatives targeted to improve employee experiences.
    - Use applicable literature reviews, successful private sector initiatives, and identified statewide agency best practices to implement new and revise existing strategies integrating employees into their units.
    - Promote existing career enhancement/advancement ladders.
    - Create virtual town halls to provide an economical, sustainable, and scalable way for statewide employees to interact with System executive staff on a more frequent basis.
    - Develop and implement an employee recognition program beyond existing Stars and eRewards programs by soliciting feedback from workers, supervisors, and directors on current best practices and then compare findings to private sector best practices.
    - Evaluate the effectiveness and scope of DFPS locality pay[381] by:

[381] The General Appropriations Act, Article II, authorizes HHS agencies to provide additional compensation to current and newly hired employees whose duty station is located in an area of the state in which the high cost of living is causing excessive employee turnover. This additional pay may not exceed $1,200 per month and is proportional to the hours worked during the month.

        - working with stakeholders and university partners to conduct a cost of living comparison for all counties in the State of Texas,
        - conducting a housing cost analysis for individuals in Region 9 to evaluate the impact of the stipend and determine if stipend amounts should be adjusted; and
        - reporting the results of such assessments by December 2016, as required by H.B. 1, Rider 41, of the 84th Legislature, Regular Session, 2015.
    - Beginning December 1, 2015, overtime (OT) payment thresholds were reduced from 240 to 140 hours. Furthermore, after December 1, the OT payment process was automated so that employees with approved OT hours exceeding 140 are automatically paid down the following month, no longer require managers to authorize payment. OT payment trends are a concern within Workforce Development, due to the short-and long-term effects on agency employee retention and turnover rates. Workforce Development plans to accomplish the following during fiscal year 2016:
    - Explore possibilities for changing when employees are paid out for OT when moving from non-exempt to exempt positions
    - Measure existing financial incentives for effectiveness in fiscal years 2016-17 include longevity pay, mentoring stipend, travel reimbursements, regular and one-time merits, CPS performance bonus, investigative stipend, Title IV-E stipend, college degree pay, on-call pay, and high-risk pay.

- Eligibility Staff:
    - Continue the Business Process Redesign initiative to streamline functions performed by eligibility staff, creating capacity to help manage workloads as caseloads increase in relation to the anticipated population growth in Texas.
    - Exploring the development of additional career tracks for clerical and eligibility staff to promote career advancement and reduce turnover.
    - Exploring the development of a mentoring program to provide structured support to eligibility staff completing training.
    - Utilizing telework across some business units and exploring expansion to others.

- Epidemiologists:
    - Consider defining a non-manager career ladder beyond Epidemiologist III for continued growth.

- Claims Examiners:
    - Review current functional job descriptions of Claims Examiners to determine if the period of time currently in place for promotions to the next

level could be reduced to allow for these employees, once trained, to work complicated cases sooner.

- Explore the possibility of having an additional Claims Examiner classification created to be more in line and competitive with their peers in other states and federal components who do the same work.

Schedule F.2: Texas Workforce System Strategic Plan

In the planning period of 2017–2021, none of the agencies in the Health and Human Services System will have a direct role in the Texas Workforce System Strategic Plan prepared by the Texas Workforce Investment Council. The Department of Assistive and Rehabilitative Services participated in the past, and these functions are being transferred, in accordance with Senate Bill 208, 84th Legislature, Regular Session, 2015, to the Texas Workforce Commission by September 1, 2016:

- Vocational Rehabilitation,
- Independent Living Services for Older Individuals Who Are Blind,
- The Criss Cole Rehabilitation Center, and
- Business Enterprises of Texas.

TEXAS HEALTH AND HUMAN SERVICES SYSTEM

2016 REPORT ON CUSTOMER SERVICE

HEALTH AND HUMAN SERVICES COMMISSION
DEPARTMENT OF AGING AND DISABILITY SERVICES
DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES
DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
DEPARTMENT OF STATE HEALTH SERVICES

June 2016

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TEXAS HEALTH AND HUMAN SERVICES SYSTEM

2016 REPORT ON CUSTOMER SERVICE

EXECUTIVE SUMMARY

This "2016 Report on Customer Service" is prepared in response to §2114.002 of the Government Code, which requires that Texas state agencies biennially submit to the Governor's Office of Budget, Planning, and Policy and the Legislative Budget Board information gathered from customers about the quality of agency services. This report reflects the cooperative efforts of the five Texas Health and Human Services (HHS) agencies that comprise the HHS system: the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), the Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC).

The HHS system vision is: a customer-focused health and human services system that provides high quality, cost-effective services resulting in improved health, safety, and greater independence for Texans.[1] Three important processes help ensure that HHS agency operations are consistent with this vision of providing quality, customer-focused services: the strategic planning process, the activities of the HHSC Office of the Ombudsman, and each HHS agency's Center for Consumer and External Affairs.

This report includes the results of over 92,000 individual survey responses from 34 surveys conducted by individual HHS agencies. Many of the surveys reported here are recurring efforts; for the most part, responses are from surveys conducted during fiscal year 2014 and fiscal year 2015. HHS agencies are using this feedback to help improve customer service.

Individual Agency Surveys

HHS agencies independently conduct surveys that include questions about customer satisfaction with specific agency programs and services. This report presents the descriptions and major findings of the following surveys.

[1] Health and Human Services System Strategic Plan 2013-2017.

Department of Aging and Disability Services

- Nursing Facility Quality Review
- Long-Term Services and Supports Quality Review
- Consumer Rights and Services Survey

Department of Assistive and Rehabilitative Services

I. Early Childhood Intervention
   - Early Childhood Intervention Family Survey

II. Division for Rehabilitation Services
   - Vocational Rehabilitation Post-eligibility Customer Satisfaction Survey
   - Vocational Rehabilitation In-plan Customer Satisfaction Survey
   - Vocational Rehabilitation Closed Case Customer Satisfaction Survey
   - Independent Living Services Customer Satisfaction Survey

III. Division for Blind Services
   - Vocational Rehabilitation Active Case Customer Satisfaction Survey
   - Vocational Rehabilitation Closed Case Customer Satisfaction Survey

Department of Family and Protective Services

I. Child Protective Services
   - National Youth in Transition Database Survey
   - Child Protective Services Alternative Response Survey

II. Adult Protective Services
   - Adult Protective Services Community Satisfaction Survey

III. Prevention and Intervention
   - Prevention and Intervention Contractor Survey

Department of State Health Services

I. Mental Health Services
   - Mental Health Statistics Improvement Program Youth Services Survey for Families
   - Mental Health Statistics Improvement Program Adult Mental Health Survey
   - Mental Health Statistics Improvement Program Inpatient Consumer Survey

II. Regulatory Services

- Regulatory Licensing Unit Customer Satisfaction Survey
- Regulatory Inspection Unit Customer Satisfaction Survey
- Professional Licensing and Certification Customer Satisfaction Survey
- Patient Quality Care Unit Customer Satisfaction Survey

III. Immunization Services

- Adult Safety Net Provider Satisfaction Survey
- Texas Vaccines for Children Provider Satisfaction Survey

IV. Specialized Health Services

- Case Management for Children and Pregnant Women Provider Survey
- Kidney Health Care Program Client Satisfaction Survey

V. Community Health Services

- Women, Infants and Children Nutrition Education Survey

VI. Laboratory Services

- Laboratory Services Courier Program Satisfaction Survey

Health and Human Services Commission

I. Children's Healthcare Coverage

- STAR Child Caregiver Member Survey
- Children's Health Insurance Program (CHIP) Caregiver Member Survey
- Medicaid and CHIP Dental Caregiver Services
- STAR Health Caregiver Member Survey

II. Adult Healthcare Coverage

- STAR Adult Member Survey
- STAR+PLUS Adult Member Survey

III. Self-service Portal for Benefits Enrollment

- YourTexasBenefits.Com Survey

Overall, the HHS system of agencies has obtained feedback from a diverse group of customers. Most customers of services provided positive feedback regarding the services and supports they received through HHS programs. These results support the HHS system vision of providing quality, customer-focused services for Texans.

INTRODUCTION

This "2016 Report on Customer Service" is prepared in response to §2114.002 of the Government Code, which requires that Texas state agencies biennially submit to the Governor's Office of Budget, Planning, and Policy and the Legislative Budget Board information gathered from customers about the quality of agency services. This report reflects the cooperative efforts of the five Texas Health and Human Services (HHS) agencies that comprise the HHS system: the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), the Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC).

Ongoing Customer Service Activities and Functions

The HHS system vision is: a customer-focused health and human services system that provides high quality, cost-effective services resulting in improved health, safety, and greater independence for Texans.[2] Three important processes help ensure that HHS agency operations are consistent with this vision of providing quality, customer-focused services: the strategic planning process, the activities of the HHSC Office of the Ombudsman, and each HHS agency's Consumer and External Affairs department.

Strategic Planning Process

The system-wide strategic plan, which is updated each biennium, facilitates the implementation of the HHS vision using strategic priorities for the HHS system. In the 2013-2017 strategic plan, HHS developed a strategic priority to "continue to enhance the service delivery system to be more coordinated, cost-effective, and customer-friendly." The strategic plan also presented the strategies the system would use for achieving this strategic priority. Throughout fiscal year 2014 and fiscal year 2015 the HHS system agencies implemented these strategies and integrated the new priority into their standard operating policies and procedures.

The strategic planning process involves examining HHS services to ensure they are aligned with the vision and priorities of the system. The array of HHS services is based on the strategic plan. Five appendices to this report present a description of services provided to customers from each agency by strategic plan budget strategy.[3]

[2] Health and Human Services System Strategic Plan 2013-2017.

[3] See Appendix A through Appendix E of this document for Customer Inventories by Agency. This information is presented in accordance with Chapter 2114.002(a) of the Government Code.

HHSC Office of the Ombudsman

HHSC's Office of the Ombudsman (OO) assists the public when the agency's normal complaint process cannot or does not satisfactorily resolve issues.[4] The mission of OO is to serve as an impartial and confidential resource, assisting consumers with health and human services-related complaints and issues.

Consumer and External Affairs

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

Previous Reports on Customer Service

In 2006 and 2008, HHS agencies worked together to develop a system-wide survey to assess the satisfaction of customers of each HHS agency. In 2006 and 2008, the surveys were comparable and included a unique group of enrollees identified by each agency. The survey questionnaire included questions about service access and choice, staff knowledge, staff courtesy, complaint handling, quality of information and communications, and internet use.

For the 2010 HHS system customer satisfaction survey, a different approach was taken. HHS agencies collaborated on a system-wide survey of children with special health care needs (CSHCN) enrolled in each HHS agency. All five HHS agencies serve CSHCN customers through a variety of programs.

In 2012 and 2014, no system-wide survey was conducted. Each HHS agency provided the results of independent customer surveys for specific agency programs. HHS agencies independently conducted surveys that include questions about customer satisfaction with specific agency programs and services. Some surveys focused entirely on customer satisfaction while others included customer satisfaction as one of several service categories being assessed. The 2016 report follows the same methods used in the 2012 and 2014 reports.

Surveys Included in 2016 Report on Customer Service

The surveys included in the 2016 Report on Customer Service are briefly described in the pages that follow (see Tables 1, 2, 3, 4, and 5). Not all customer satisfaction surveys conducted by HHS agencies are included here; some that had research designs that did not hold up to scientific rigor or that had very low response rates are not included. There were 92,135 individual responses to the surveys that are reported here.

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

Table 1. Surveys Conducted by the Department of Aging and Disability Services

Name	Data Collection	N	Survey Population
Nursing Facility Quality Review*	6/2013 - 8/2013	2,166	Individuals living in Medicaid-certified nursing facilities in Texas
Long-Term Services and Supports Quality Review**	4/2013 – 10/2013	5,899	People receiving services and supports through home, community-based, and institutional programs offered by DADS
Consumer Rights and Services Survey	9/2013 – 8/2014 4/2015 – 8/2015	2,329 1,879	People who file complaints through the Consumer Rights and Services Complaint Intake Call Center
Total		**12,273**	

* The large, legislatively mandated, recurring Nursing Facility Quality Review involves data collection and analysis that span a period of multiple years. The most recent Nursing Family Quality Review, published in January 2015, uses survey data collected in 2013.

**The large, legislatively mandated, recurring Long-Term Services and Supports Quality Review also involves data collection and analysis that span multiple years. The most recent Long-Term Services and Supports Quality Review, published in January 2015, uses data collected in 2013.

Table 2. Surveys Conducted by the Department of Assistive and Rehabilitative Services

Name	Data Collection	N	Survey Population
Early Childhood Intervention			
Early Childhood Intervention Family Survey	2/2015 – 6/2015	2,271	Parents of children enrolled in the DARS Early Childhood Intervention (ECI) program, which serves children from birth to 36 months of age who have developmental delays or disabilities
Division for Rehabilitation Services			
Vocational Rehabilitation (VR) Post-eligibility Customer Satisfaction Survey	10/2013 – 9/2014 10/2014 – 9/2015	1,224 1,278	Customers who have applied for VR services (employment support for people with disabilities) and were found eligible but have not yet received services
VR In-plan Customer Satisfaction Survey	10/2013 – 9/2014 10/2014 – 9/2015	2,367 2,566	Customers receiving VR services
VR Closed Case Customer Satisfaction Survey	10/2013 – 9/2014 10/2014 – 9/2015	3,527 3,936	Customers who had received VR services in the previous fiscal year whose cases had been closed
Independent Living Services Customer Satisfaction Survey	10/2013 – 9/2014 10/2014 – 9/2015	422 205	Customers who had received Independent Living Services (support to help people with disabilities live independently) and whose cases had been closed
Division for Blind Services			
VR Active Case Customer Satisfaction Survey	10/2013 – 9/2014 7/2015 – 10/2015	480 552	People who were blind or had other visual impairments and who were receiving VR services
VR Closed Case Customer Satisfaction Survey	10/2013 – 9/2014 7/2015 – 10/2015	998 986	People who were blind or had other visual impairments, who had received VR services, and whose cases were closed
Total		**20,812**	

Table 3. Surveys Conducted by the Department of Family and Protective Services

Name	Data Collection	N	Survey Population
Child Protective Services			
National Youth in Transition Database Survey	10/2013 – 9/2014	1,117	Young adults who have been involved with the foster care system
Child Protective Services Alternative Response Survey	10/2014 - 10/2015	329	Families receiving Alternative Response services and a comparison group receiving formal investigations
Adult Protective Services			
Adult Protective Services Community Satisfaction Survey	4/2015 - 6/2015	588	Stakeholders of Adult Protective Services (members of the judiciary, law enforcement agencies, community organizations and resource groups, and community boards)
Prevention and Early Intervention			
Prevention and Intervention Contractor Survey	12/2014	77	Prevention and Early Intervention contractors who provide prevention services to at-risk youth and families
Total		**2,111**	

Table 4. Surveys Conducted by the Department of State Health Services

Name	Data Collection	N	Survey Population
Mental Health Services			
Mental Health Statistics Improvement Program Youth Services Survey for Families	3/2014 - 8/2014 3/2015 - 9/2015	593 219	Parents of children/adolescents age 17 or younger who received community-based mental health services from the DSHS Mental Health and Substance Abuse Division
Mental Health Statistics Improvement Program Adult Mental Health Survey	3/2014 - 8/2014 3/2015 - 9/2015	544 334	Adults age 18 or older who received community-based mental health services from the DSHS Mental Health and Substance Abuse Division
Mental Health Statistics Improvement Program Inpatient Consumer Survey	9/2013 – 8/2014 9/2014 – 8/2015	3,505 3,251	Adolescents (ages 13-18) and adults who received services in state-run psychiatric hospitals
Regulatory Services			
Regulatory Licensing Unit Customer Satisfaction Survey	9/2013 – 8/2014 9/2014 – 8/2015	205 354	Customers of the Regulatory Licensing Unit (businesses and facilities regulated by the state)
Regulatory Inspection Unit Customer Satisfaction Survey	3/2104 - 8/2015	277	Customers of the Regulatory Inspection Unit (entities regulated by the state)
Professional Licensing and Certification Customer Satisfaction Survey	9/2013 – 8/2014 9/2014 – 8/2015	330 1,107	Customers of the Professional Licensing and Certification Unit (healthcare professionals licensed by the state)
Patient Quality Care Unit (PQCU) Customer Satisfaction Survey	9/2013 – 8/2014 9/2014 – 8/2015	325 364	Customers of PQCU (licensed and or certified individuals, providers, and health care facilities that operate in Texas)
Immunization Services			
Adult Safety Net Provider Satisfaction Survey	11/2014 - 12/2014	230	Health care providers registered with the Adult Safety Net program
Texas Vaccines for Children	8/2014	1,025	Health care providers registered with the Texas Vaccines for Children program

Name	Data Collection	N	Survey Population
Specialized Health Services			
Case Management for Children and Pregnant Women Provider Survey	6/2015	148	Active, inactive, and closed case management providers
Kidney Health Care Program Client Satisfaction Survey	10/2013 - 12/2013	1,119	Kidney Health Care program clients
Community Health Services			
Women, Infants and Children Nutrition Education Survey	4/2014	3,405	Adults who received nutrition education through the Women, Infants and Children program
Laboratory Services			
Laboratory Services Courier Program Satisfaction Survey	8/2014	156	Customers of the Laboratory Services Courier program
Total		**17,491**	

Table 5. Surveys Conducted by the Health and Human Services Commission

Name	Data Collection	N	Survey Population
Children's Healthcare Coverage			
STAR Child Caregiver Member Survey	5/2015 - 8/2015	4,148	Caregivers of children who received services funded through the Medicaid STAR program
Children's Health Insurance Program (CHIP) Caregiver Member Survey	5/2015 - 8/2015	3,689	Caregivers of children who received services through CHIP
Medicaid and CHIP Dental Caregiver Survey	6/2015 - 9/2015	1,204	Caregivers of children receiving dental health services through the Medicaid and CHIP programs
STAR Health Caregiver Member Survey	8/2014 - 11/2014	301	Caregivers of children and adolescents in foster care who were enrolled in STAR Health

Name	Data Collection	N	Survey Population
Adult Healthcare Coverage			
STAR Adult Member Survey	6/2014 - 8/2014	3,627	Adults who received services funded through the Medicaid STAR program
STAR+PLUS Adult Member Survey	6/2014 - 8/2014	5,843	Adults with disabilities who received services through the STAR+PLUS program
Self-service Portal for Benefits Enrollment			
YourTexasBenefits.Com Survey	1/2015 – 12/2015	20,636	Customers who used YourTexasBenefits.com to manage or enroll in benefits
Total		**39,448**	

Report Format

This 2016 Customer Satisfaction Report presents summaries of the results of customer surveys conducted by DADS, DARS, DFPS, DSHS, and HHSC. Each summary includes the sample and survey methods, the main findings and, if available, a link to the full report. These results present important information about customer satisfaction with services provided by HHS agencies.

Since §2114.002 of the Government Code requires that HHS agencies gather information from their customers about the quality of services, the term "customers" is used where appropriate throughout this report to indicate individuals who receive services from HHS agencies. Of note, many of the HHS agencies more commonly use the term "consumer" or "individual" to refer to service recipients.

Appendix F presents a glossary of acronyms used in this report.

DEPARTMENT OF AGING AND DISABILITY SERVICES

This report includes three customer service surveys from the Department of Aging and Disability Services (DADS). The two largest surveys are the Nursing Facility Quality Review (NFQR) and Long-Term Services and Supports Quality Review (LTSSQR). Both of these quality reviews are legislatively mandated and assess the satisfaction, quality of care, and quality of life of individuals who reside in nursing facilities and individuals who receive other long-term services and supports.[5] Funds are appropriated for quality reviews every other year and quality review reports are published biennially. These large, recurring quality reviews involve data collection and analysis that span a period of multiple years. The most recent NFQR and LTSSQR, both published in January 2015, use survey data collected in 2013. Together, they represent the views of over 8,000 individuals.

In addition to these two quality review surveys, the Consumer Rights and Services (CRS) survey is also included in this report. Through the surveys reported here, DADS collected over 12,000 survey responses during this period regarding customers' experiences and satisfaction with services.

Nursing Facility Quality Review

Purpose

Data collection for the NFQR 2013 was conducted between June and August 2013. The NFQR consisted of in-person interviews and chart reviews of randomly selected people living in Medicaid-certified nursing facilities across the state. The purpose of the NFQR was to assess the quality of care and the quality of life for individuals in these nursing facilities. NFQR data collected over time helps DADS to track progress in quality improvement activities and formulate strategies to improve both the quality of care and quality of life for residents of Texas nursing facilities

This survey has been conducted since 2002. Between 2002 and 2010, the NFQR was completed on an annual basis. Since 2011, the NFQR has been conducted on a biennial basis. What follows is a summary of the results from the NFQR 2013. The full report is available at: http://www.dads.state.tx.us/news_info/publications/legislative/nfqr2013/index.html.

Sample and Methods

In order to assess the quality of life of older individuals who reside in nursing facilities, DADS adopted an instrument that was developed in 1998 by the University of Minnesota School of Public Health.[6] The survey emphasized the psychological and social aspects of quality of life.

[5] For both 2010-2011 and 2012-2013 biennia: General Appropriations Act, Article II, Department of Aging and Disability Services, Rider 13.

[6] Kane, R. A. (2003). Measures, indicators, & improvement of quality of life in nursing homes: Quality of life scales for nursing home residents. Retrieved from: http://www.hpm.umn.edu/ltcresourcecenter/research/QOL/QOL_of_Scales_and_how_to_use_them.pdf

DADS modified the survey by including additional questions about physical health, quality of care, and quality of life.

DADS contracted with the Nurse Aide Competency Evaluation Service Plus Foundation, Inc. (NACES) to survey and assess randomly selected nursing facility residents across the state. The sample size for NFQR 2013 was determined by the number of Minimum Data Set assessments submitted in fiscal year 2012. NACES completed 2,166 face-to-face interviews from June to August 2013. The interviews were conducted in English, although interpreters were available to translate for individuals who spoke other primary languages.

DADS staff analyzed the NFQR 2013 data for linear trends across time, either from the first year data were collected on a particular measure, or when there was a change in the wording of a question that prevented comparison to the data from previous years.

Major Findings

The NFQR assesses many clinical measures of well-being, but this report focuses on the quality of life and customer satisfaction findings, which are summarized in Tables 6, 7 and 8. The 2013 NFQR results show that most of the residents surveyed were satisfied overall. This finding was not significantly different from previous surveys. Several of the specific satisfaction measures showed statistically significant improvements over time, while one measure showed a statistically significant decrease since the previous data collection.

Table 6. NFQR Overall Satisfaction Findings:
Indicated Somewhat Satisfied, Satisfied, or Very Satisfied*

Satisfaction Measure	2008 Proportion of Respondents** (N=2,129)	2009 Proportion of Respondents** (N=2,164)	2012 Proportion of Respondents** (N=2,172)	2013 Proportion of Respondents** (N=2,166)
Expressed satisfaction with their experience in the nursing facility	88%	88%	90%	88%
Expressed satisfaction with the healthcare services they received	88%	89%	90%	90%

*The 2013 survey was conducted from June to August 2013.
**Proportions indicate respondents who chose responses "somewhat satisfied," "satisfied," or "very satisfied" rather than "somewhat dissatisfied," "dissatisfied," or "very dissatisfied." Those who did not answer the survey question are not counted in these proportions.

Table 7. NFQR Specific Satisfaction Findings:
Indicated Somewhat Satisfied, Satisfied, or Very Satisfied*

Satisfaction Measure	2008 Proportion of Respondents** (N=2,129)	2009 Proportion of Respondents** (N=2,164)	2012 Proportion of Respondents** (N=2,172)	2013 Proportion of Respondents** (N=2,166)
Satisfied with their level of pain control	95%	95%	92%	92%
Enjoyed organized activities at the nursing facility	64%	62%	62%	63%
Stated weekend activities (other than religious activities) were available	40%	44%	49%	52%
Liked the food served at the facility	84%	85%	85%	83%
Reported that they enjoy meal times at the facility	87%	87%	89%	89%
Stated that their favorite foods were available at the facility	67%	67%	71%	66%
Felt that their possessions were safe at the facility	89%	89%	92%	88%
Felt safe and secure at the nursing facility	97%	98%	98%	97%

*The 2013 survey was conducted from June to August 2013.
**Proportions indicate respondents who chose responses "somewhat satisfied," "satisfied," or "very satisfied" rather than "somewhat dissatisfied," "dissatisfied," or "very dissatisfied." Those who did not answer the survey question are not counted in these proportions.

Table 8. NFQR Specific Satisfaction Findings:
Indicated Yes when answering these questions*

Satisfaction Measure	2012 Proportion of Respondents** (N=2,172)	2013 Proportion of Respondents** (N=2,166)
Had concerns the facility did not address	13%	15%
Stated they had concerns they did not express due to fear of retaliation	4%	7%

*The 2013 survey was conducted from June to August 2013.
**Proportions indicate respondents who responded "yes" to these questions. Those who did not answer the survey question are not counted in these proportions.

Long Term Services and Supports Quality Review

Purpose

The Long Term Services and Supports Quality Review (LTSSQR) is a statewide survey of people receiving services and supports through home and community-based and institutional programs offered by DADS. The purpose of the LTSSQR is to:

- Inquire about customers' perceptions of the quality of long-term services and supports administered by DADS and quality of life
- Trend satisfaction results for long-term services and supports over time

This quality review is legislatively mandated and assesses the satisfaction, quality of care, and quality of life of individuals who receive long-term services and supports. The quality review process has been conducted since 2005 as a continued activity of a Real Choice Systems Change Grant awarded by the Centers for Medicare and Medicaid Services (CMS). People receiving services, or their family members and guardians, provide feedback about the services received through face-to-face and mailed surveys. The surveys and interviews also collect data about quality of life, which encompasses aspects of a person's life that are not necessarily related to the direct delivery of services or supports (e.g. whether a person has relationships or friends). The LTSSQR provides baseline information for continuous quality improvement, monitoring, and intervention. The survey also helps the agency build a quality management strategy, identify trends, develop innovations, and provide information to stakeholders and CMS.

DADS contracted with NACES to conduct face-to-face interviews with randomly selected clients across the state.

The summary report is available at:
http://www.dads.state.tx.us/news_info/publications/legislative/ltssqr2014/index.html.

Sample and Methods

The 2014 LTSSQR was conducted between April and November 2013. Individuals eligible for inclusion included adults receiving long-term services and supports from DADS and/or their families or guardians, and families or guardians of children receiving services. There were three primary sub-groups within the survey population:

- Adults with intellectual and developmental disabilities (IDD)
- Adults with physical disabilities (primarily older adults)
- Children with disabilities

The DADS adult population was stratified by Medicaid waiver or other long-term services and supports programs and a random sample was drawn from each program for a representative sample.

Adults in the following programs were interviewed face-to-face (4,469 completed interviews):

- Community Attendant Services
- Community Based Alternatives
- Community Living Assistance and Support Services
- Consumer Managed Personal Attendant Services
- Day Activity and Health Services
- Deaf Blind with Multiple Disabilities
- Family Care
- Home and Community-Based Services
- Hospice
- Host Home Care
- In-Home Family Support
- Intermediate Care Facility/IDD
- Primary Home Care
- Programs of All-Inclusive Care for the Elderly
- Residential Care
- Special Services to Persons with Disabilities
- Special Services to Persons with Disabilities with 24-hour Shared Attendant Care
- State Supported Living Centers (SSLC)
- Texas Home Living

DADS mailed surveys to families of children who receive services through DADS-administered programs. Like the adult programs, representative samples were drawn from each program so that findings could be generalized to all individuals in a program.

Families of children enrolled in the following programs returned surveys (1,430 families):

- Community Living Assistance and Support
- Home and Community-Based Services
- Medically Dependent Children Program
- Texas Home Living

Both the surveys disseminated by mail and face-to-face interviews were available in English or Spanish. Additionally, some face-to-face interviews were conducted with individuals who spoke languages other than English or Spanish using interpreters.

Adults received one of two LTSSQR surveys: the National Core Indicators (NCI) Adult Consumer Survey or the Participant Experience Survey. Families of children received the NCI Child and Family Survey about the family's satisfaction with services.

The total number of completed responses was 5,899 individuals for an overall response rate of greater than 90 percent (the response rate varied between populations surveyed).

Major Findings

General observations for the 2014 LTSSQR include:

Health and Welfare

- Texas adults with IDD received more routine and preventive health care than people with IDD nationally, and also received significantly higher rates of care on six of 11 health indicators.
- Adults with IDD living in state supported living centers or community-based housing received higher rates of routine and preventive care than those living with family.

Safety

- Most adult respondents reported that they were not scared at home (85 percent) or in their day programs (94 percent).
- By report, the majority (93 percent) had someone to talk to if they were afraid.

Choice and Respect

- Most respondents felt like they could make decisions about taking risks, helping other people, choosing their schedule, what to do with free time, and what to buy with their money.
- Control over transportation remains an issue; less than half of respondents in some programs reported having control over their transportation.
- Less than half of the adult respondents made decisions about where they live, who they live with, and where they go during the day.
- Most respondents reported that staff listened to them, were respectful, and had never hurt them or taken their things without asking.

Community Inclusion

- Most adult respondents had close relationships and could see their friends and family when they wanted.
- By report, the majority (98 percent of adults with IDD and 81 percent of children) participated in community activities.

Employment

- While most adults with IDD were unemployed (77 percent), 46 percent of them wanted to work.
- Barriers to employment included a lack of training or education, a lack of job opportunities, a lack of transportation, and a lack of job supports.

Quality of Life

- Most respondents had close relationships and could see their friends whenever they wanted.
- About eight in ten respondents were happy with their personal life.
- Just under half of the respondents who reside in SSLCs reported feeling lonely.
- Helping children and families make connections in the community is an area with opportunities to improve quality of life.

Access

- More than half of the respondents reported having enough information to help plan their services or apply for services – 82 percent for adults with IDD, 76 percent with physical disabilities, and 54 percent of the families of children with disabilities.
- The majority of adults with IDD and families of children with disabilities reported that they received, or their service plans included, all of the services they needed (82 percent and 78 percent, respectively).
- The most commonly specified needs were: finding or changing jobs, education and training, help in the social or relationship areas, transportation and dental care.
- Failure to receive needed equipment decreased between 2005 and 2013, from 15 percent to 11 percent.

Quality of Care

- The majority of respondents reported that their long-term services and supports helped with their health and well-being and in reaching their personal goals.
- Eighty percent of the families of children with disabilities reported that services were available when they needed them, and 75 percent reported flexible services and supports, which usually changed to meet their family member's changing needs.
- Most people reported that their case manager returned calls promptly, staff came to work on time, and that their support workers have the right training.

Consumer Rights and Services Survey

Purpose

Consumer Rights and Services (CRS) receives complaints about the treatment of older adults and people with disabilities in Texas, as well as complaints about nursing homes, assisted living facilities, adult day cares, and other long-term services and supports providers overseen by DADS. DADS staff investigates these complaints and notifies the person who made the complaint of the findings. Additionally, the Consumer Rights and Services staff provides information about DADS services and supports through their website and hotline.

Offering call center surveys allows CRS to look at call center performance and overall customer satisfaction rates. Customer comments and suggestions provide highly actionable information and insight for increasing and sustaining customer satisfaction. The survey results are used as a resource to identify areas of efficiency and areas of opportunity for improvement.

The study population is comprised of callers who contacted the Complaint Intake Call Center September 1, 2013 through August 31, 2015.

Sample and Methods

This ongoing survey has been collected or distributed since May 2006. Prior to November 2012, the survey was conducted by mailing survey requests to individuals who filed complaints through the CRS hotline for the following facility types: nursing facilities, privately owned intermediate care facilities for people with intellectual and developmental disabilities, SSLCs, and licensed or certified home health hospice centers. Surveys were not sent to addresses for anonymous complainants. To achieve business efficiencies, the methods for conducting surveys changed in November 2012. The survey link was added to the CRS website, and CRS discontinued mailing the surveys via U.S. mail. Complainants were offered the option of providing an email address to receive the link to the online survey at the time of intake. If the client did not provide an email address, the intake specialist verbally provided the survey link. The survey was available in both English and Spanish. The email option was discontinued after at the end of fiscal year 2014. In April 2015, CRS transitioned to an automated survey which replaced the previous survey option. Upon completion of intake, the caller is transferred directly into an automated phone survey system immediately after the call has concluded. Both methodologies of the survey instrument includes six customer satisfaction questions with responses on a 5-point Likert scale of "strongly agree," "agree," "neutral," "disagree," and "strongly disagree."

The study sought responses from customers who contacted CRS or who requested contact from CRS as a result of inquiry, voice mail, or entry through the provider self-reported web-portal. The surveys/interviews were offered in English and Spanish.

CRS received 2,329 completed surveys in fiscal year 2014 and 1,879 completed surveys in fiscal year 2015. Given the nature of the data collection methodology in fiscal year 2014 (e.g. through a link on the website) and the staff's discretion on which clients to invite to take the survey, the

response rate could not be calculated. For fiscal year 2015, the response rate is calculated by the number of callers transferred into the automated survey system. Fiscal year 2015 data represent surveys completed between April and August 2015. It is still at the staff's discretion as to which clients are given the opportunity to complete the survey. Survey offers are contingent upon the type of call and complainant.[7]

Major Findings

Customer satisfaction findings from the CRS Survey are presented in Table 9. The distribution methods changed between fiscal years 2014 and 2015 and may be partially responsible for differences in results between years. Overall, 95 percent customers were satisfied with the services they received from CRS.

Table 9. Consumer Rights and Services Survey Selected Findings: Indicated Strongly Agreed or Agreed

Satisfaction Measure	Fiscal Year 2014* Proportion of Respondents** (N=2,329)	Fiscal Year 2015* Proportion of Respondents** (N=1879)
Consumer Rights and Services hotline was easy to use	97%	94%
Person I spoke with explained the process for handling my complaint	93%	90%
Overall, satisfied with Consumer Rights and Services	97%	94%

*The fiscal year 2014 survey was conducted from September 2013 to August 2014. The fiscal year 2015 survey was conducted from April to August 2015.
** Proportions indicate respondents who chose responses "strongly agreed," or "agreed" rather than "neutral," "disagreed," or "strongly disagreed." Those who did not answer the survey question are not counted in these proportions.

[7] In instances in which individuals call CRS to report extreme trauma, such as rape, staff members are instructed to use their discretion about whether to provide the customer satisfaction survey information. The intake staff members did not provide the customer satisfaction link or after April 2015 transfer customer to automated survey if they believe that doing so will further burden the complainants or make them feel that their experiences have been trivialized.

DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES

The Department of Assistive and Rehabilitative Services (DARS) submitted seven reports containing customer satisfaction data for the current report. Over 20,800 responses were received in response to these surveys. The interviews solicited feedback from parents of young children who received Early Childhood Intervention (ECI) services and from adults and youth who received vocational rehabilitation and independent living services.

For readability, this chapter is organized in three sections:

I. Early Childhood Intervention

   a. Early Childhood Intervention Family Survey

II. Division for Rehabilitation Services

   a. Vocational Rehabilitation Post-eligibility Customer Satisfaction Survey

   b. Vocational Rehabilitation In-plan Customer Satisfaction Survey

   c. Vocational Rehabilitation Closed-case Customer Satisfaction Survey

   d. Independent Living Services Customer Satisfaction Survey

III. Division for Blind Services

   a. Vocational Rehabilitation Active Case Customer Satisfaction Survey

   b. Vocational Rehabilitation Closed Case Customer Satisfaction Survey

I. Early Childhood Intervention

Early Childhood Intervention Family Survey

Purpose

Early Childhood Intervention (ECI) serves children from birth to 36 months of age who have developmental delays or disabilities as well as their families. The program provides early intervention services to help families and caregivers strengthen their ability to improve the child's development through everyday activities in the home and community. Services are provided through a statewide system of community-based programs. The family survey is administered to a sample of parents or caregivers every year.

The purpose of the annual survey is to assess:

- Family perceptions of ECI services, including customer satisfaction
- Families' experiences with ECI services and service providers

- Families' recorded competencies in helping their children develop and learn

The survey is administered in compliance with the regulations for early intervention programs from the Office of Special Education Programs (OSEP) at the U.S. Department of Education.

Statewide data are reported as part of DARS Division for ECI Services' Annual Performance Report to OSEP.

The survey/series of interviews was conducted by DARS Division for ECI Services and through the 49 contracted agencies who deliver ECI services. The survey materials were prepared by DARS Division for ECI Services. Surveys were mailed and emailed to families by DARS. Contracted agencies delivered survey materials to families directly.

The study population was parents or guardians of children who had been enrolled in the ECI program for at least six months as of February 1, 2015. This criterion was established to ensure the family had sufficient experience with the program to respond to the questions.

Sample and Methods

DARS Division for ECI Services used multiple methods to deliver surveys and select samples. Families were not included in more than one sample. The following methodologies were used:

- 538 families who met the six month criteria and had a listed email address in the DARS Division for ECI Services' database were sent an email request to complete the survey with a link to an online version of the survey. The online surveys were emailed in February of 2015.

- 400 families were randomly selected to receive a packet mailed directly to them by DARS. These packets were mailed in March of 2015. The packet included the paper survey, a postage-paid return envelope, a letter explaining the survey, and a pencil. The letter of explanation included a link to an online version of the survey so families could complete it online if they preferred.

- A random sample of 7,303 families was selected to receive a survey packet from their ECI service coordinator. The packet included the paper survey, a postage-paid return envelope, a letter explaining the survey, and a pencil. The letter of explanation included a link to an online version of the survey so families could complete it online if they preferred. These surveys were delivered between March and May 2015.

The surveys were offered online and in a paper form in English and Spanish. All versions of the survey contained the same questions and response options. Surveys were collected through June 2015.

Individuals provided their responses by completing the survey online or by completing the paper survey and mailing it to DARS Division for ECI Services in the postage-paid envelope included in their packet. If families requested assistance in completing the survey, ECI service coordinators were instructed to find another community resource for this assistance so ECI staff would not be involved in completing the survey.

Of the 8,241 surveys sent out by DARS Division for ECI Services, 1,786 were undeliverable due to changes in address or email address, the family discharging from ECI, or the service coordinator being unable to reach the family. A total of 6,455 surveys were delivered to ECI families.

The total number of completed responses was 2,271 out of 6,455 for a response rate of 35 percent.

Major Findings

For all questions, a majority of the families indicated that ECI was very or extremely helpful. Ninety-three percent of families reported that ECI helped their children develop and learn.

Responses to survey questions were combined into composite scores for the three domains measured by the survey instrument, following federally recommended procedures. The percentage of respondents who agreed that early intervention services helped with each of the three domains, based on their composite scores, is shown below.

Family Experiences with Services

- 87 percent felt early intervention services helped the family members know their rights
- 88 percent felt early intervention services helped the family members effectively communicate their children's needs
- 89 percent felt early intervention services helped the family members help their children develop and learn

II. Division for Rehabilitation Services

Among the services provided by the Division for Rehabilitation Services (DRS), a part of DARS, are Vocational Rehabilitation (VR) and Independent Living Services (ILS). DRS conducted four surveys to solicit customer satisfaction feedback, three for VR customers and one for ILS customers.

The VR program provides services to help Texans with disabilities prepare for, find, and keep employment. This program also helps students with disabilities make the transition from school to work. Eligibility criteria for this program include: the presence of a physical or mental disability that results in a substantial impediment to employment, whether the individual is employable after receiving services, and whether services are required to achieve employment outcomes. The services to help people with disabilities find and keep employment are individualized and may include counseling, training, medical treatment, assistive devices, job placement assistance, and other services.

The three surveys that DRS used to solicit feedback from VR customers varied based on which stage the customers had reached in their relationship with DRS:

- *Post-eligibility customers* are individuals who have applied for and been found eligible for VR services but have not yet developed an Individualized Plan for Employment, which is the basis for determining which services they will receive.

- *In-plan customers* are individuals who have an open case and are receiving services based on their Individualized Plan for Employment.

- *Closed-case customers* are individuals who had vocational rehabilitation services cases that have been closed during the fiscal year.

The fourth survey solicited feedback from customers of the ILS program. The ILS program is designed to help individuals with disabilities who face barriers that limit their choices for quality of life. The ILS program helps people in this situation to live independently; engage in a self-directed lifestyle; decrease their dependence on family members and; improve their communication, mobility, and/or personal or social adjustment.

Services provided in the ILS program may include:

- counseling and guidance

- training and tutorial services

- adult basic education

- rehabilitation facility training

- vehicle modifications

- assistive devices such as artificial limbs, braces, wheelchairs and hearing aids to stabilize or improve function

DRS provides VR services and ILS for people with disabilities other than blindness or other visual impairments. Services for people who are blind or have other substantial visual impairments are administered by a different division of DARS and will be discussed later in this chapter.

All four surveys were conducted by contractors, who were asked to reach a fixed number of interviews. The response rates for the surveys were not provided.

Vocational Rehabilitation Post-eligibility Customer Satisfaction Survey

Purpose

The VR Post-eligibility Customer Satisfaction Survey solicits feedback from individuals who have applied for VR services and been found eligible, but who have not yet developed and signed their individualized plans for employment. The individualized plan for employment identifies the customer's employment goal and the services that will be provided to reach that goal.

The purpose of the VR post-eligibility customer satisfaction survey was to:

- Identify strengths and weaknesses
- Develop strategies on providing excellent services to customers
- Determine areas of needed improvement

The survey was conducted by contractors. The study population was customers who applied for VR services and were found eligible, but had not yet developed and signed their individual plans for employment. Customers who met this criterion from October 2014 through September 2015 were included in the survey sample.

The VR post-eligibility customer satisfaction survey is conducted in compliance with federal requirements. Results are provided to the state rehabilitation council (the Rehabilitation Council of Texas).

Sample and Methods

A randomly selected sample of customers, stratified by DRS region, was drawn to receive the survey. A contractor attempted to contact each customer in the sample by telephone to conduct an interview. The interviews were offered in English and in Spanish. Additionally, customers who spoke languages besides English or Spanish were offered the opportunity to complete the survey using a language translation hotline. The survey was offered to deaf customers using Relay Texas[8] or a written survey, depending on the preferences of the customer or, when applicable, the customer's guardian. The survey was conducted each month for customers served in the previous month.

The survey instrument included ten closed-ended and one open-ended question.

The results discussed here are from surveys of customers in post-eligibility status in fiscal year 2014 and 2015. For fiscal year 2014, there were 1,224 completed surveys. For fiscal year 2015, there were 1,278 completed surveys.

Summary of Major Findings

Overall, more than 84 percent of VR post-eligibility customers in both fiscal years 2014 and 2015 said they were satisfied with their overall experience with DARS (see Table 10). When comparing the survey results for both years, customer positive responses were within 2.4 percentage points for all questions. This difference is not statistically significant.

[8] Relay Texas is a service that provides telephone access for people with speech or hearing loss who find it challenging or impossible to use a traditional telephone. Additional information about Relay Texas can be found at: http://www.relaytexas.com/english.html.

Table 10. Vocational Rehabilitation Post-eligibility Customer Satisfaction Survey: Positive Responses

Survey Question	Fiscal Year 2014* Proportion of Respondents** (N=1,224)	Fiscal Year 2015* Proportion of Respondents** (N=1,278)
Are you treated in a friendly, caring, and respectful manner when you dealt/deal with DRS staff?	95%	93%
When you have a scheduled appointment, are you seen within 15 minutes of your scheduled appointment time?	87%	88%
Does the counselor maintain communication with you regarding the process of your case?	76%	76%
Do DRS staff demonstrate a can-do attitude while working with you?	92%	91%
Does someone from the DRS office return all your calls no later than the next business day?	70%	68%
Do DRS staff explain when and why appointments were/are scheduled with them?	82%	84%
Do DRS staff provide you with the guidance you needed/need?	82%	82%
Have your services been interrupted because of a change or the absence of your counselor? ("No" is considered a positive response in this item.)	83%	82%
On a scale of 1 to 4, with 4 being very satisfied, how would you rate your satisfaction with your DRS counselor?	85%	85%
One a scale of 1 to 4, with 4 being very satisfied, how would you rate your overall experience with DRS?	85%	85%

*The fiscal year 2014 survey was conducted from October 2013 to September 2014. The fiscal year 2015 survey was conducted from October 2014 to September 2015.
**The proportion of respondents represents the proportion giving a positive answer to each question. For questions with "yes," "sometimes," or "no" answers, the proportion of positive responses are those answered in the direction of the desired outcome. For questions where the possible answers included "very satisfied," "satisfied," "dissatisfied," and "very dissatisfied," "very satisfied" and "satisfied" were counted as positive responses.

There was one open-ended question on the VR post-eligibility customer satisfaction survey: "Based on your experience, how can DRS be more helpful?" In fiscal years 2014 and 2015, the most common responses to this question were related to the following three categories: client

contact issues (e.g., appointments, phone calls, and other client contact), policy/procedures-related issues, and service issues related to employment.

Vocational Rehabilitation In-plan Customer Satisfaction Survey

Purpose

The Vocational Rehabilitation In-plan Customer Satisfaction Survey solicits feedback from VR customers whose individualized plans for employment had been developed and signed and who had an open case at the time of the survey.

The purpose of the VR in-plan customer satisfaction survey was to:

- Identify strengths and weaknesses of the program
- Develop strategies on providing excellent services to customers
- Determine areas of needed improvement

The survey was conducted by contractors. The study population was customers who have signed individual plans for employment. Customers who met this criterion in fiscal year 2014 and 2015 were included in the survey sample.

The VR in-plan customer satisfaction survey is conducted in compliance with federal requirements. Results are provided to the state rehabilitation council (the Rehabilitation Council of Texas).

Sample and Methods

The telephone-based survey method was the same used for the VR post-eligibility customer satisfaction survey. The survey instrument contained eighteen closed-ended questions and one open-ended question. The survey was conducted each month for customers served in the previous month.

The results discussed here are for customers who met the in-plan criteria in fiscal year 2014 and 2015. For fiscal year 2014, there were 2,367 completed surveys. For fiscal year 2015, there were 2,566 completed surveys.

Summary of Findings

Overall, the majority (88 percent) of in-plan customers in both fiscal year 2014 and 2015 said they were satisfied with their overall experience with DARS (see Table 11). When comparing the survey results, the percent of customers who responded positively to questions in fiscal year 2014 and 2015 were within three percentage points for all but two questions. For those questions, there was a 3.5 percent decrease in customers reporting they had input in planning the services

they received and a 4.6 percent decrease in customers reporting their services were not interrupted in federal fiscal year 2015.

Table 11. Vocational Rehabilitation In-plan Customer Satisfaction Survey: Positive Responses

Survey Question	Fiscal Year 2014* Proportion of Respondents** (N=2,367)	Fiscal Year 2015* Proportion of Respondents** (N=2,566)
Are you treated in a friendly, caring, and respectful manner when you dealt/deal with DRS staff?	95%	94%
When you have a scheduled appointment, are you seen within 15 minutes of your scheduled appointment time?	92%	91%
Does the counselor maintain communication with you regarding the process of your case?	84%	82%
Do DRS staff demonstrate a can-do attitude while working with you?	93%	92%
Does someone from the DRS office return all your calls no later than the next business day?	77%	76%
Do DRS staff explain when and why appointments were/are scheduled with them?	88%	87%
Do you and your counselor maintain contact as often as agreed upon while you were/are receiving services?	84%	82%
Are you satisfied with the explanation of services to help you reach your goal?	87%	86%
Do you have input (take part) in setting your employment goals?	88%	86%
Do you agree with the employment goal you and your counselor have chosen?	86%	87%
Did you have input (take part) in planning the services you received?	88%	85%
Did you and your counselor discuss when services would begin and end?	81%	79%

Survey Question	Fiscal Year 2014* Proportion of Respondents** (N=2,367)	Fiscal Year 2015* Proportion of Respondents** (N=2,566)
Did you have input (take part) in choosing who would provide the services (schools or colleges, doctors or hospitals, job coaches, etc.)?	78%	75%
Do DRS staff provide you the guidance you needed/need?	87%	85%
Have your services been interrupted because of a change or the absence of your counselor? ("no" = services not interrupted)	83%	78%
On a scale of 1 to 4, with 4 being very satisfied, how satisfied were you with the services you received from service providers your counselor sent you to?	86%	84%
On a scale of 1 to 4, with 4 being very satisfied, how would you rate your satisfaction with your DRS counselor?	89%	88%
On a scale of 1 to 4, with 4 being very satisfied, how would you rate your overall experience with DRS?	89%	88%

*The fiscal year 2014 survey was conducted from October 2013 to September 2014. The fiscal year 2015 survey was conducted from October 2014 to September 2015.

**The proportion of respondents represents the proportion giving a positive answer to each question. For questions with "yes," "sometimes," or "no" answers, the proportion of positive responses are those answered in the direction of the desired outcome. For questions where the possible answers included "very satisfied," "satisfied," "dissatisfied," and "very dissatisfied," "very satisfied" and "satisfied" were counted as positive responses.

There was a single open-ended question on the VR in-plan customer satisfaction survey: "Based on your experience, how can DRS be more helpful?" In fiscal year 2014, 38.1 percent of respondents answered this question with a specific suggestion or question. The most commonly given open-ended responses to the question were in two areas: client contact issues (e.g., wanting more client contact, increased follow through, more use of email contact, more communication and similar requests) and services issues related to employment. In fiscal year 2015, client contact issues and employment issues were also the most frequently cited comments.

Vocational Rehabilitation Closed-case Customer Satisfaction Survey

Purpose

The Vocational Rehabilitation Closed-case Customer Satisfaction Survey solicits feedback from VR customers who have received VR services and whose cases have been closed during the month prior to the month they are surveyed.

The purpose of the VR closed-case customer satisfaction survey was to:

- Identify strengths and weaknesses of the program
- Develop strategies on providing excellent services to customers
- Determine areas of needed improvement

The VR closed-case customer satisfaction survey was conducted in compliance with federal requirements. Results were provided to the state rehabilitation council (the Rehabilitation Council of Texas).

Sample and Methods

The VR closed-case customer satisfaction survey has been conducted for decades, with periodic revisions. The telephone-based survey method was the same used for VR post-eligibility and in-plan customer satisfaction surveys. The survey instrument contained twenty closed-ended questions and one open-ended question. The survey was conducted each month for customers served in the previous month.

The results discussed here are from surveys of customers in fiscal year 2014 and 2015. For fiscal year 2014, there were 3,527 completed surveys. For fiscal year 2015, there were 3,936 completed surveys.

Summary of Major Findings

The majority of customers surveyed (90 percent in fiscal year 2014 and 91 percent in fiscal year 2015) said they were satisfied with their overall experience with DRS (see Table 12). Customer responses to questions fiscal year 2014 and 2015 were within less than two percentage points, with the exception of a 5.4 percent increase in customers reporting that they were working and a 4.3 percent increase in satisfaction with chance for advancement in fiscal year 2015.

When comparing responses to similar questions in all three VR surveys, satisfaction tends to increase over time as customers become more engaged with the VR process. The lowest satisfaction is reported by customers who have just been determined eligible for services, and the highest satisfaction is reported by customers with individualized plans for employment whose cases have just been closed.

Table 12. Vocational Rehabilitation Closed-case Customer Satisfaction Survey: Positive Responses

Survey Question	Fiscal Year 2014* Proportion of Respondents** (N=3,527)	Fiscal Year 2015* Proportion of Respondents** (N=3,936)
Were you treated in a friendly, caring, and respectful manner when you dealt with DRS staff?	94%	95%
Did DRS staff demonstrate a can-do attitude while working with you?	93%	93%
Did someone from the DRS office return all your calls no later than the next business day?	80%	81%
Did DRS staff explain when and why appointments were scheduled with them?	90%	91%
Did you and your counselor maintain contact as often as agreed upon while you were receiving services?	88%	89%
Were you satisfied with the explanation of services to help you reach your goal?	89%	89%
Did you have input (take part) in setting your employment goals?	88%	87%
Did you have input (take part) in planning the services you received?	87%	88%
Did you and your counselor discuss when services would begin and end?	86%	85%
Did you have input (take part) in choosing who would provide the services (schools or colleges, doctors or hospitals, job coaches, etc.)?	76%	76%
Did DRS staff provide you the guidance you needed?	87%	89%
Were your services interrupted because of a change or the absence of your counselor? ["No" = services were not interrupted]	85%	84%
On a scale of 1 to 4, with 4 being very satisfied, how satisfied were you with the services you received from service providers your counselor sent you to?	87%	88%
On a scale of 1 to 4, how would you rate your satisfaction with your DRS counselor?	90%	91%
On a scale of 1 to 4, how would you rate your overall experience with DRS?	90%	91%

Survey Question	Fiscal Year 2014* Proportion of Respondents** (N=3,527)	Fiscal Year 2015* Proportion of Respondents** (N=3,936)
Are you working now?	69%	74%
On a scale of 1 to 4, with 4 being very satisfied, please rate your satisfaction with: Your wages.	80%	80%
On a scale of 1 to 4, with 4 being very satisfied, please rate your satisfaction with: Your employee benefits (vacation, sick leave, health insurance)***	83%	83%
On a scale of 1 to 4, with 4 being very satisfied, please rate your satisfaction with: Your chance for advancement.	62%	66%
On a scale of 1 to 4, with 4 being very satisfied, please rate your satisfaction with: Your job overall.	89%	89%

*The fiscal year 2014 survey was conducted from October 2013 to September 2014. The fiscal year 2015 survey was conducted from October 2014 to September 2015.
** The proportion of respondents represents the proportion giving a positive answer to each question. For questions with "yes," "sometimes," or "no" answers, the proportion of positive responses are those answered in the direction of the desired outcome. For questions where the possible answers included "very satisfied," "satisfied," "dissatisfied," and "very dissatisfied," "very satisfied" and "satisfied" were counted as positive responses.
***For those that had benefits, the "no benefits" category was excluded from the question.

There was a single open-ended question on the survey asking how can DRS can be more helpful. In fiscal years 2014 and 2015, the most commonly given open-ended responses were in two areas: services issues related to employment (e.g., responses related to finding a job, finding a better job, better paying jobs, more job alternatives, and similar suggestions and requests) and client contact issues (e.g., wanting more client contact, returned phone calls, increased follow-through, more use of email contact, and more communication).

Independent Living Services Customer Satisfaction Survey

Purpose

Independent Living Centers and the ILS program promote self-sufficiency for people with disabilities and offer supports related to mobility, communication, personal adjustment, and self-direction. Independent Living Centers are operated by and for people with disabilities and provide assistance through peer counseling, information and referral, advocacy support, and other measures that encourage people to make their own decisions.

This report provides feedback from customers in the ILS program who received services from DARS and whose cases were closed within fiscal years 2014 and 2015. The survey was conducted by contractors.

The purpose of the ongoing ILS customer satisfaction survey was to:

- Identify strengths and weaknesses
- Develop strategies on providing excellent services to customers
- Determine areas of needed improvement

The ILS customer satisfaction survey was conducted in compliance with the federal program requirements that ILS program must have a survey mechanism in place to obtain satisfaction feedback from its customers. Additionally, this survey provides the State Independent Living Council data necessary to fulfill its obligation to review and analyze customer satisfaction with the DRS ILS program.

Sample and Methods

The ILS customer satisfaction survey was conducted using the same telephone interviewing protocol as the three VR customer satisfaction surveys. However, since the ILS population is small, an attempt was made to contact every ILS customer who had reached the stage of developing and signing a plan and whose case was closed during the fiscal year. However, due to ILS program budget constraints, for fiscal year 2015 the vendor was required to set a cap on the number of completed surveys like the cap that is in place for the three VR surveys. The response rate for the fiscal year 2014 ILS survey was 42.8 percent. Due to the change in methods, no response rate was captured for the fiscal year 2015 ILS survey. The survey instrument consisted of thirteen close-ended questions and two open-ended questions.

The results discussed here are from 422 surveys of ILS customers whose cases were closed in fiscal year 2014 and 205 surveys for ILS customers whose cases were closed in fiscal year 2015. During fiscal year 2014, 2,502 ILS customers received services from the DRS ILS program and 2,796 during fiscal year 2015.

Summary of Major Findings

In both fiscal year 2014 and 2015 over 96 percent of respondents said they were satisfied with their overall experience with DRS (see Table 13). Over 99 percent of respondents said they were treated with courtesy by the DRS staff. Customer responses in fiscal years 2014 and 2015 were within two percentage points for all questions with the exception of the question asking customers if they took part in choosing who would provide their services, for which there was a 2.8 percent decrease in positive responses from fiscal year 2014 to 2015.

Table 13. Independent Living Services Customer Satisfaction Survey: Positive Responses

Survey Question	Fiscal Year 2014* Proportion of Respondents** (N = 422)	Fiscal Year 2015* Proportion of Respondents** (N = 205)
I was treated with courtesy by the DRS staff.	100%	99%
The DRS Independent Living counselor took time to listen to my needs.	99%	97%
I took part in planning the services I received.	97%	98%
My DRS Independent Living counselor encouraged me to be more independent.	96%	95%
My DRS Independent Living counselor gave me choices.	93%	93%
If I were ever treated unfairly, I believe my DRS Independent Living counselor would be a help to me.	96%	96%
As a result of the services I received, I can do more for myself.	93%	94%
As a result of the services I received, I can do more in the community, if I want to.	85%	87%
I took part in choosing who would provide services.	87%	84%
I was satisfied with how long it took to provide the services.	89%	87%
I was satisfied with the services I received from the providers.	97%	97%
How would you rate your experience with the DRS Independent Living counselor?	98%	96%
How would you rate your overall experience with DRS?	97%	96%

*The fiscal year 2014 survey was conducted from October 2013 to September 2014. The fiscal year 2015 survey was conducted from October 2014 to September 2015.

** The proportion of respondents represents the proportion giving a positive answer to each question. For questions with "yes," "sometimes," or "no" answers, the proportion of positive responses are those answered in the direction of the desired outcome. For questions where the possible answers included "very satisfied," "satisfied," "dissatisfied," and "very dissatisfied," "very satisfied" and "satisfied" were counted as positive responses.

The survey also included an open-ended question**:** "What did you like most about your experience with DRS?" In fiscal year 2014, the most common responses to this question were that DRS treated customers courteously, DRS staff was helpful, the services were liked, and DRS was responsive. In fiscal year 2015, the most common responses to this question were that

DRS was helpful, DRS was responsive, DRS treated customers courteously, and the equipment was liked.

A second open-ended question on the survey was: "What did you dislike most about your experience with DRS?" In both fiscal year 2014 and 2015, the most common responses to this question concerned timeliness of services. The issue of timeliness of services was also the most frequently mentioned specific issue disliked about services in federal fiscal years 2011, 2012, and 2013.

III. Division for Blind Services

The Division for Blind Services (DBS) provides Vocational Rehabilitation (VR) services to Texans who are blind or have a substantial visual impairment. The VR program provides services to help Texans gain the confidence and skills needed to obtain or maintain employment.

This section presents the results of two annual customer satisfaction surveys for the DBS VR program: one for active cases and one for closed cases. These data are used to identify areas where caseload carrying staff need to improve their delivery of consumer services.

For all surveys, the interviews were conducted over the phone by an independent contractor in English, Spanish, or Vietnamese, and deaf-blind customers had the opportunity to complete the survey through Relay Texas.[9]

The study population was customers receiving or completing services in fiscal years 2014 and 2015.

Vocational Rehabilitation Active Case Customer Satisfaction Survey

Purpose

The DBS VR active case customer satisfaction survey solicits feedback from customers who have an open case at the time of the survey. The purpose of this survey was to:

- Assess customer satisfaction with DBS staff members
- Assess customer satisfaction with the services

The DBS VR active case customer satisfaction survey solicits feedback through telephone interviews conducted by an independent contractor. The contractor was asked to reach a fixed number of telephone interviews for the survey of VR customers actively receiving services, and the response rates were not provided.

[9] Relay Texas is a service that provides telephone access for people with speech or hearing loss who find it challenging or impossible to use a traditional telephone. Additional information about Relay Texas can be found at: http://www.relaytexas.com/english.html.

Sample and Methods

For fiscal year 2014, interviews were conducted every month for cases that were active in the previous month. For fiscal year 2015, interviews were conducted between July and October for cases which were active during the fiscal year. There were 480 completed interviews in federal fiscal year 2014 and 522 in federal fiscal year 2015. The survey instrument contained eight questions.

Summary of Major Findings

In fiscal year 2014 the lowest positive response was 86 percent and in fiscal year 2015 the lowest positive response was 81 percent (see Table 14). The greatest increase from fiscal year 2014 to 2015 was a six percent increase in positive responses regarding whether respondents were very involved in choosing their employment goal.

Table 14. Vocational Rehabilitation Active Case Customer Satisfaction Survey: Positive Responses

Survey Questions	Fiscal Year 2014* Proportion of Respondents** (N=480)	Fiscal Year 2015* Proportion of Respondents** (N=552)
My counselor does a good job of explaining what's going on.	96%	90%
My counselor does a good job of staying in touch with me regarding the process of my case.	89%	81%
I agreed to the evaluations that were set up for me.	97%	95%
Evaluations and other services were provided on a timely basis.	87%	87%
I was actively involved in choosing my employment goal.	86%	92%
I was actively involved in choosing the services and service providers to help me achieve my employment goal.	87%	87%
My understanding of how my progress toward my employment goal will be evaluated is: (Clear and very clear combined)	86%	84%
My understanding of my responsibilities and the agency's responsibilities regarding my Individualized Plan for Employment (IPE) is: (Clear and very clear combined)	93%	88%

*The fiscal year 2014 survey was conducted from October 2013 to September 2014. The fiscal year 2015 survey was conducted from October 2014 to September 2015.

** The proportion of respondents represents the proportion giving a positive answer to each question. For questions with "yes," "sometimes," or "no" answers, the proportion of positive responses are those answered in the direction of the desired outcome. For questions where the possible answers included "very satisfied," "satisfied," "dissatisfied," and "very dissatisfied," "very satisfied" and "satisfied" were counted as positive responses.

Vocational Rehabilitation Closed Case Customer Satisfaction Survey

Purpose

The DBS VR Closed Case Customer Satisfaction Survey solicits feedback from VR customers who have received VR services and whose cases have been closed. An independent contractor conducted the survey.

The purpose of the DBS VR closed case customer satisfaction survey was to:

- Assess customer satisfaction with DBS staff members
- Assess customer satisfaction with the services

Sample and Methods

To be eligible for inclusion in the survey, the customer must have received services under a plan of services and the case must have been closed. Attempts were made to contact every eligible customer rather than selecting a sample. To increase the response rate, phone interviews were conducted. Customers were contacted by phone by an independent contractor between October 2013 and September 2014 for cases closed in fiscal year 2014 and between July 2015 and October 2015 for cases closed in fiscal year 2015. The survey instrument contained ten questions.

Summary of Major Findings

Telephone interviews were completed by 998 clients in fiscal year 2014 and 986 clients in fiscal year 2015. Every score went down between fiscal year 2014 and 2015 (see Table 15). DBS believes that this is related to selecting a new independent contractor to conduct surveys. In previous years, survey was conducted within a month of case closure. The delayed process could create recall problems for some individuals and make others more difficult to locate.

Table 15. Vocational Rehabilitation Closed Cases Customer Satisfaction Survey: Positive Responses

	Fiscal Year 2014*	Fiscal Year 2015*
	Proportion of Respondents**	Proportion of Respondents**
Survey Questions	(N=998)	(N=986)
I have increased skills because of the services I received through DBS.	93%	80%
My counselor listened to and considered my needs and concerns.	94%	86%
I was an active partner in making decisions.	96%	90%
I was actively involved in choosing my employment goal and the services I received.	93%	88%
I received the services my counselor and I planned.	94%	86%
I received my planned services within a reasonable period of time.	90%	82%
The services I received through DBS helped me obtain or maintain my job.	92%	83%
My job is a good match for what I was looking for.	88%	80%
After I became employed my counselor contacted me at least one time before my case was closed. (Yes)	92%	84%
How would you rate your overall experience with the Division for Blind Services?	92%	89%

*The fiscal year 2014 survey was conducted from October 2013 to September 2014. The fiscal year 2015 survey was conducted from October 2014 to September 2015.

** The proportion of respondents represents the proportion giving a positive answer to each question. For questions with "yes," "sometimes," or "no" answers, the proportion of positive responses are those answered in the direction of the desired outcome. For questions where the possible answers included "very satisfied," "satisfied," "dissatisfied," and "very dissatisfied," "very satisfied" and "satisfied" were counted as positive responses.

Four surveys from three programs of the Texas Department of Family and Protective Services (DFPS) are presented in this report: Child Protective Services (CPS), Adult Protective Services (APS), and Prevention and Early Intervention (PEI) services. CPS submitted the results of two surveys. One solicited the feedback of young adults who are currently, or were formerly, in foster care and the other assessed the satisfaction of clients receiving alternative response services. APS submitted the results of one survey that collected data from stakeholders. PEI submitted the results of a survey of their prevention services contractors. There were 2,111 survey responses received by DFPS, and of those 1,446 were from CPS, 588 from APS, and 77 from PEI.

I. Child Protective Services

National Youth in Transition Database Survey

Purpose

Youth and young adults who have been involved in the foster care system are at high risk for difficult outcomes during the transition to adulthood. These outcomes include homelessness, not finishing high school, early parenthood, unemployment, dependence on public benefits, and involvement in the criminal justice system. To gather data about these concerns, the U.S. Department of Health and Human Services' Administration for Children and Families (ACF) created the John H. Chafee Foster Care Independence Program (CFCIP). CFCIP established the data quality standards. The organization also administers grants to states that collect data about persons involved in the foster care system.

DFPS contributes to this national data collection effort called the National Youth in Transition Database (NYTD) by conducting surveys of current and former foster care youth and young adults. The data from Texas and other states are collected and provided to the federal government for NYTD which in turn are stored in the National Data Archive on Child Abuse and Neglect at Cornell University and are ultimately made available to researchers.[10]

NYTD is a longitudinal study that tracks outcomes of youth and young adults who have been involved with the foster care system. Every three years, states collect data on a new cohort of 17 year old youth in foster care, which comprises data for the study. Two years later at age 19, a random sample of the youth with baseline data is surveyed again. Finally, this random sample is surveyed again two years later, when they are age 21. These data allow researchers to assess the outcomes these youth experience when they leave foster care and transition to adult living.

In federal fiscal year 2013, DFPS staff surveyed 17 year old youth who were in foster care in Texas within 45 days after their birthday. Topics addressed in the survey included:

[10] The datasets are available at: http://www.ndacan.cornell.edu/datasets/datasets-list-ncands-child-file-dcdc.cfm.

- Employment
- Educational attainment
- Parenting
- Health care coverage
- Use of public benefits or other types of aid, such as scholarships
- Homelessness
- Drug or alcohol use
- Involvement with the criminal justice system
- Connection to adults as a source of emotional support
- Demographic information

Sample and Methods

DFPS surveyed youth who were in foster care at some point within 45 days after their 17th birthday.[11] This survey population is considered to be the baseline for Cohort 2, as every third year a new baseline of youth is surveyed. DFPS collected surveys between October 1, 2013 and September 30, 2014. There were 1,384 youth identified in the baseline survey population and DFPS Preparation for Adult Living (PAL) staff contacted them through multiple modes to complete the survey. The survey and survey request were distributed and completed in several ways:

- Paper survey: in person and through the mail
- Online: through email and through an on-line portal on a website
- Phone
- Text

The survey was offered in English and Spanish. DFPS staff were available to read questions and provide an explanation of the survey questions if needed. Since the survey asked about sensitive topics, the youth who were contacted for the survey were assured of their confidentiality.

Youth completed 1,117 surveys, for a response rate of 81 percent. Reasons for non-participation in the survey are as follows:

- Unable to locate - 7%
- Runaway/missing - 6%
- Youth declined - 5%
- Incapacitated - 2%
- Parent declined - <1%

[11] Foster care as defined in 45 Code of Federal Regulations 1355.20, available at: https://www.gpo.gov/fdsys/granule/CFR-2011-title45-vol4/CFR-2011-title45-vol4-sec1355-20.

- Incarcerated - <1%

Major Findings

Outcomes reported by survey participants are grouped into the following topics: financial self-sufficiency, educational attainment, connection to adults, Medicaid coverage, high risk behaviors, and homelessness. Results have been organized into protective factors and/or desired outcomes, risk factors and/or concerning outcomes, and public assistance.

National Youth in Transition Database Survey: Protective Factors and/or Desired Outcomes

The results of the survey show that 93 percent of the youth are enrolled in high school, 93 percent have a connection to a positive adult, and 13 percent are currently employed (see Table 16).

Table 16. NYTD Survey Federal Fiscal Year 2014: Protective Factors and/or Desired Outcomes*

Topic	Reported by Survey Respondents	Proportion of Respondents (N=1,117)
Financial self-sufficiency	Currently employed full-time or part-time	13%
	Have employment related training skills	20%
Educational attainment	Enrolled in and attending high school	93%
	Finished high school or GED	5%
	Receiving educational financial aid	4%
Connection to adults	Have a current positive connection to an adult	93%
Health Insurance	Have Medicaid coverage	94%
	Have health insurance other than Medicaid	4%

*The federal fiscal year 2014 survey was conducted from October 2013 to September 2014.

National Youth in Transition Database Survey: Risk Factors and/or Concerning Outcomes

An examination of the results related to risk factors and concerning outcomes reveals that 32 percent have been incarcerated sometime in their life, 20 percent have been homeless sometime in their life and 6 percent have had children (see Table 17).

Table 17. NYTD Survey Federal Fiscal Year 2014: Risk Factors and/or Concerning Outcomes*

Topic	Reported by Survey Respondents	Proportion of Respondents (N=1,117)
High risk behaviors (in lifetime)	Substance abuse referral	18%
	Have been incarcerated	32%
	Have given birth or fathered any children	6%
Homelessness (in lifetime)	Have been homeless	20%

*The federal fiscal year 2014 survey was conducted from October 2013 to September 2014.

National Youth in Transition Database Survey: Public Assistance

Finally, an analysis of the survey results related to public assistance revealed that 10 percent of respondents receive social security. There were no other questions related to public assistance (other than what has been included in the above categories) on the baseline survey.

Child Protective Services Alternative Response Survey

Purpose

The CPS Alternative Response (AR) program provides referrals for low-risk families that are reported for abuse or neglect, but do not need a formal investigation. The purpose of the survey/series of interviews was to compare the satisfaction of families in the AR stage of service with a comparable group of families having formal investigations.

The survey/series of interviews was conducted by the Analytics and Evaluation Team of CPS. The study population was families completing AR and a control group of comparable families receiving formal abuse or neglect investigations.

Sample and Methods

The study sought responses from:

- All families completing AR since its inception in Texas in November, 2014
- A convenience sample of comparable families for whom a formal investigation was completed in the same region and in comparably sized units which had not yet implemented AR

- All families in comparable completed investigations in the AR areas one month before the November, 2014 implementation.

The families were identified through data in the CPS IMPACT system. The study was conducted by mail surveys from October 2014 through October 2015. The surveys/interviews were offered in English and Spanish. Individuals provided responses by mail or online.

In total, 329 surveys were completed out of 5,405, for a response rate of 6 percent. Other than the information provided here, the data and results from the AR survey have not been published.

Major Findings

Table 18 provides the major findings of the survey.

- A higher percentage of families were satisfied with how they were treated by an AR caseworker than by a traditional investigations caseworker.
- A higher percentage of families felt the caseworker understood the family's needs in an AR case than in a traditional investigations case.
- AR cases had a lower percentage of families who felt important things were not discussed.
- More AR families felt better off after CPS experience than did traditional investigations families.
- There was little difference between the families in the two groups in regards to whether they felt they were a better parent because of their experience with CPS or whether they felt their children were safer because of their experience with CPS.

Table 18. Alternative Response Program and Control Group Survey Responses*

Survey Questions	Alternative Response (N=174)	Traditional Investigations (N=155)
Treatment by Caseworker		
Very satisfied with how treated by caseworker	84%	74%
Somewhat satisfied with how treated by caseworker	11%	14%
Not at all satisfied with how treated by caseworker	5%	12%
Feels the caseworker understood the family's needs	90%	82%
Had important things that were not discussed	14%	26%

Survey Questions	Alternative Response (N=174)	Traditional Investigations (N=155)
Impact of experience with CPS		
The family was better off because of the experience with Child Protective Services	61%	58%
The family was no better or worse off because of the experience with Child Protective Services	36%	31%
The family was worse off because of the experience with Child Protective Services	3%	11%
Felt they were a better parent because of their experience with CPS	71%	71%
Felt their children were safer because of their experience with CPS	71%	73%

*The survey was conducted October 2014 through October 2015.

II. Adult Protective Services

Adult Protective Services Community Satisfaction Survey

Purpose

The APS In-Home program investigates allegations of abuse, neglect, and financial exploitation of adults who are elderly or have disabilities and live in their own homes or in unlicensed room-and-board homes. APS may also provide or arrange for emergency services to alleviate or prevent further abuse, neglect, or financial exploitation.

The purpose of the survey was to meet the legislative requirements of Human Resources Code §48.006, which requires the agency to gather information on APS performance in providing investigative and adult protective services. APS uses results of the survey to benefit APS clients by developing strategies to sustain community support, augment local community networks, strengthen volunteer programs, and develop resources in Texas communities.

The 2015 survey was conducted by APS, and is the eighth community satisfaction survey on APS investigations and services. The survey is sent every other year and builds on the initial study conducted by HHSC in November 2004.

The study population was members of the judiciary, law enforcement agencies, community organizations and resource groups, and APS community boards.

The survey results can be found at the DFPS website:
https://www.dfps.state.tx.us/Adult_Protection/About_Adult_Protective_Services/survey.asp.

Sample and Methods

The study sought responses from stakeholder groups in the APS system, including local law enforcement agencies and prosecutors' offices, courts with jurisdiction over probate matters, members of the judiciary, community organizations and resource groups, and APS community board members. The 2015 web-based survey sought responses from the entire census or population list for each stakeholder group.

The survey was conducted by online questionnaires via Survey Monkey, by mail, and by fax between April 27, 2015, and June 1, 2015. The surveys were offered in English only.

An email was sent to potential respondents with instructions for accessing and completing the online survey. APS faxed or mailed paper surveys to individuals upon request or to those individuals who may not have Internet access based on the regional staff's knowledge of stakeholders and their experience with them.

Minor revisions were made to the 2015 questionnaire, simplifying survey instructions and eliminating the "not applicable" response category. The 2015 questionnaire consisted of Likert-scale statements and open-ended questions that measured the extent of respondent awareness of APS involvement in the community and perceptions of APS staff capability, effectiveness, and professionalism. Response categories ranged from "strongly agree" to "strongly disagree" and included a "neutral" category. The survey also included open-ended questions to solicit comments from respondents.

The total number of completed surveys was 588 out of a total of 2,768 survey requests for a response rate of 21 percent.

Major Findings

The survey responses indicate that APS community engagement efforts are effective. The results reinforce the continued need for outreach efforts and continued collaboration with local communities, law enforcement, and the judiciary. These survey results also provide valuable insight for making improvements and strengthening partnerships with civic and professional organizations at the local and state level. APS will continue to assess, strengthen, and improve relationships with the judiciary and law enforcement.

Category 1 of Findings (Safety and Dignity)

- Most stakeholder groups either "agreed" or "strongly agreed" with the statement, "APS ensures the safety and dignity of vulnerable adults in this community."
- Agreement with the statement ranged from 82 percent to 93 percent across community organizations, community boards, and law enforcement stakeholder groups.

- The agreement among members of the judiciary was 56 percent.

Category 2 of Findings (Quality of Working Relationships)

- Most stakeholder groups either "agreed" or "strongly agreed" that "There is a good working relationship between [community organizations, law enforcement, and the judiciary] and APS in this community."

- Agreement with the statement ranged from 73 percent to 90 percent.

Category 3 of Findings (Understanding of APS Mission)

- The majority of community board members, community organizations, and law enforcement representatives either "agreed" or "strongly agreed" with the statement, "I understand APS's mission, scope, and purpose."

- Ninety-six percent of community board members, 87 percent of community organization respondents, and 74 percent of law enforcement respondents agreed with the statement.

Category 4 of Findings (Judiciary Results)

- The majority of the judiciary respondents reported that APS cases "rarely" or "sometimes" appear before their court (40 percent and 27 percent, respectively).

- The data indicated that the majority of judiciary respondents, approximately 65 percent, either "agreed" or "strongly agreed" with the survey statement, "APS caseworkers are prepared in dealings with the court," and 61 percent either "agreed" or "strongly agreed" that "APS seeks appropriate court action."

Category 5 of Findings (Law Enforcement Results)

- The majority of law enforcement respondents reported that they "often" or "sometimes" work with their local APS office (21 percent and 47 percent, respectively).

- Approximately, 75 percent of the respondents "agreed" or "strongly agreed" that "Referrals to law enforcement from APS are appropriate."

- Additionally, approximately 72 percent of respondents "agreed" or "strongly agreed" with the statement "APS staff members are prepared with information and facts when working with law enforcement on APS cases."

Category 6 of Findings (Community Organizations Results)

- The majority of community organization respondents reported that their agency "sometimes" or "often" interacts with APS (39 percent and 38 percent, respectively).

- A majority (78 percent) of respondents either "agreed" or "strongly agreed" with the statement, "Referrals to my agency from APS are appropriate."

- Eighty-nine percent of community organization respondents "agreed" or "strongly agreed" with the statement, "APS is an important component of my community's resource and social service network."

Category 7 of Findings (Community Boards Results)

- Ninety-six percent of respondents reported that they "agreed" or "strongly agreed" with the statement, "APS is an important component of my community's resource network."
- Ninety percent of respondents reported that they "agreed" or "strongly agreed" with the statement, "The board has a good working relationship with APS."

III. Prevention and Intervention

Prevention and Early Intervention Contractor Survey

Purpose

PEI works to prevent abuse, neglect, delinquency, and truancy of Texas children by:

- Managing community-based programs that prevent child abuse and juvenile delinquency
- Helping communities identify their prevention needs and enhance local services
- Helping communities create new programs and improve existing ones that improve outcomes for children, youth, and their families

PEI contracts for a number of prevention services statewide that are available to the public free or a low cost. Some of these services are available statewide and others are only available in certain areas. The program serves at-risk children and families through services such as crisis counseling, home visiting, parenting education classes, and support groups. The services are intended to promote protective factors and reduce risk factors to yield positive outcomes for children and families.

The purpose of the survey was to obtain input on perceived strengths, weaknesses, opportunities, and threats in relation to the PEI division. The survey was conducted by the DFPS Center for Policy Innovation and Program Coordination in order to maintain confidentiality of the results and objectivity in the survey process.

Sample and Methods

The survey sought responses from 132 PEI contractors, consisting of 70 program contacts and 62 program directors. The study was conducted through an online survey and was only offered in English. It began on December 8, 2014 and concluded on Friday December 19, 2014. Individuals provided responses by completing the survey themselves through the survey link. The survey had a 58 percent response rate with 77 out of 132 contractors participating in the survey.

Major Findings

- The major strength identified by respondents is the quality of the collaboration with community organizations such as school districts, courts, YMCAs, and counties.
- Another strength identified is a "better organized, new positive and more professional attitude in PEI." Contractors reported that there is a general attitude of partnership in the last few years that was not there before. Contractors commended both PEI and DFPS leadership for creating an environment of partnership and positivity.
- The major challenge reported is difficulty in meeting monthly target numbers. For instance, some programs are required to serve a certain number of unduplicated clients/youth each month.
- Another challenge reported is the database delays which consume too much time on data entry and developing reports.
- A major opportunity identified is to expand and strengthen prevention efforts through proactive marketing and education with an emphasis on prevention as opposed to protective services.
- A major threat mentioned by respondents is any potential loss of funding which would affect programming and thereby affect the provision of needed services in Texas communities.

DEPARTMENT OF STATE HEALTH SERVICES

This chapter reports the results of nine surveys that collected customer satisfaction data regarding Texas Department of State Health Services (DSHS) services. More than 39,000 responses were received in response to these surveys. Surveys included adults and the parents of children receiving mental health services, and customers of regulatory, immunization, specialized health, community health, and laboratory services.

For readability, this chapter is organized in six sections:

I. Mental Health Services
   a. Mental Health Statistics Improvement Program Youth Services Survey for Families
   b. Mental Health Statistics Improvement Program Adult Services Survey
   c. Mental Health Statistics Program Inpatient Consumer Survey

II. Regulatory Services
   a. Regulatory Licensing Unit Customer Satisfaction Survey
   b. Regulatory Inspection Unit Customer Service Survey
   c. Professional Licensing and Certification Customer Satisfaction Survey
   d. Patient Quality Care Unit Customer Satisfaction Surveys

III. Immunization Services
   a. Adult Safety Net Provider Satisfaction Survey
   b. Texas Vaccines for Children Provider Satisfaction Survey

IV. Specialized Health Services
   a. Case Management for Children and Pregnant Women Provider Survey
   b. Kidney Health Care Program Client Satisfaction Survey

V. Community Health Services
   a. Women, Infants, and Children Nutrition Education Survey

VI. Laboratory Services
   a. Laboratory Services Courier Program Satisfaction Survey

Mental Health Statistics Improvement Program Youth Services Survey for Families

Purpose

Every year since 1997, Texas has surveyed customers who received community-based mental health services from the DSHS Mental Health and Substance Abuse Division about their perceptions of the mental health services they received. When the customers who received services are age 17 or younger, the parents or guardians receive the Youth Services Survey for Families (YSSF).

The purpose of the YSSF is to measure:

- Parental satisfaction with mental health services received through the state mental health system
- Parental perception of these services along multiple dimensions, including access to care and outcomes of services

Sample and Methods

The YSSF survey administered in fiscal year 2014 and fiscal year 2015 consisted of 26 items. Each question assessed information about a specific topic and was strongly related to a group of other questions about the same topic. The survey questions fell into seven of these groups of related questions, or domains. The domains that comprised the YSSF survey were:

- Satisfaction (with services)
- Participation in treatment
- Cultural sensitivity (of staff)
- Access (to services)
- Outcomes (of services)
- Social connectedness
- Functioning

The domains are described in more detail in the Summary of Findings.

Parents/guardians of patients answered each survey question using a five-point Likert scale ranging from "strongly agree" to "strongly disagree." Survey results focus on the domain "agreement rates" which means the percentage of parents that reported "agree" or "strongly agree" to the items in a domain. The survey was administered in English and Spanish.

In both years, a random sample was identified to receive the survey requests. In fiscal year 2014, the sample was stratified by two groups: one for NorthSTAR and one for community mental health centers, local entities that contract with the state to deliver mental health services[12]; 2,420 received survey invitations.[13] In fiscal year 2015, 1,354 received survey invitations.[14]

In fiscal year 2014, there were a total of 593 completed questionnaires. The survey had a response rate of 25 percent. In fiscal year 2015, there were a total of 219 completed questionnaires. The survey had a response rate of 16 percent.

Summary of Findings

The results of the most recent survey year (fiscal year 2015) are shown in Table 19. The percentages indicate the proportion of respondents who answered "agree" or "strongly agree" to questions in the stated domain.[15, 16] For instance, 76 percent of respondents agreed or strongly agreed with the items in the Satisfaction domain.

[12] Community mental health centers are also called Local Mental Health Authorities. For more information, see http://www.dshs.state.tx.us/mhcommunity/default.shtm.
[13] There were of 2,610 children/adolescents in the sample and 190 surveys were undeliverable.
[14] There were 1,508 children/adolescents in the sample and 154 surveys were undeliverable.
[15] For 2014, results were adjusted by weighting the NorthSTAR and Community Mental Health strata to their population sizes to obtain domain agreement rates that can be generalized statewide.
[16] For each domain, only respondents who answered two-thirds or more of the items comprising that domain were included in the calculation.

Table 19. Mental Health Statistics Improvement Program Youth Services Survey for Families: Indicated Strongly Agree or Agree with Domains

Domain	Description of Domain	Fiscal Year 2015* Proportion of Respondents** (N=219)
Satisfaction (with services)	Would the parent choose these services for his/her child if there were other options available?	76%
Participation in Treatment Planning	Does the parent feel involved in treatment decisions?	86%
Cultural Sensitivity (of staff)	Does staff show respect for the family's race/ethnicity/ culture?	90%
Access (to services)	Are services available when and where needed?	73%
Outcomes (of services)	As a result of services, has the child's functioning at home and school improved and has he/she experienced fewer mental health symptoms?	56%
Social Connectedness	Does the child feel connected to friends, family, and community?	76%
Functioning	Has the child's overall well-being improved?	57%

*The fiscal year 2015 survey was conducted from March to September 2015.
** Proportions indicate respondents who selected answer choices "strongly agree" or "agree" rather than "neutral," disagree," or "strongly disagree."

Domain agreement rates did not differ substantially between fiscal year 2014 and fiscal year 2015.

Mental Health Statistics Improvement Program Adult Mental Health Survey

Purpose

The Adult Mental Health Survey (AMH) asked customers who received community-based mental health services from the DSHS Mental Health and Substance Abuse Division about their perceptions of the mental health services they received. Adults age 18 years or older who recently received a mental health service beyond an intake assessment were eligible for inclusion in the survey. The purpose of the survey was to measure:

- Customer satisfaction with mental health services received through the state mental health system
- Customer perception of these services along multiple dimensions, including access to care and outcomes of services.

Sample and Methods

The AMH survey, administered in both English and Spanish, consists of 36 questions about mental health services the customer received over the past 12 months.

Each question assessed information about a specific topic and was strongly related to a group of other questions about the same topic. The survey questions fell into seven of these groups of related questions, or domains. The domains that comprised the AMH survey were:

- Satisfaction (with services)
- Access
- Quality and Appropriateness (of services)
- Participation in Treatment Planning
- Outcomes (of services)
- Functioning
- Social Connectedness

The domains are described in more detail in the Summary of Findings.

In both years, DSHS used random sampling to identify a population to receive the survey requests. In fiscal year 2014, the sample was stratified into two groups: one for NorthSTAR and one for community mental health centers. In fiscal year 2014, 2,225 adults received survey invitations.[17] In fiscal year 2015, 1,285 adults received survey invitations.[18] In fiscal year 2014, there were a total of 544 completed questionnaires. The survey had a response rate of 24 percent. In fiscal year 2015, there were a total of 334 completed questionnaires. The survey had a response rate of 26 percent.

Summary of Findings

The results of the most recent survey year (fiscal year 2015) are shown below. The percentages in Table 20 indicate the percent of respondents who answered "agree" or "strongly agree" to questions in the stated domain.[19] For instance, 80 percent of respondents agreed or strongly agreed with the items in the Satisfaction domain.

[17] The sample drawn was of 2,454 individuals and 229 surveys were undeliverable.
[18] The sample drawn was of 1,508 individuals and 154 surveys were undeliverable.
[19] For each domain, only respondents who answered two-thirds or more of the items comprising that domain were included in the calculation.

Table 20. Mental Health Statistics Improvement Program Adult Mental Health Survey: Indicated Strongly Agree or Agree with Domains

Domain	Description of Domain	Fiscal Year 2015* Proportion of Respondents** (N=334)
Satisfaction (with services)	Would the consumer choose to receive these services if he or she had other options?	80%
Access (to services)	Are sufficient services available when and where needed?	75%
Quality and Appropriateness (of services)	Is staff competent and are the services professional?	78%
Participation in Treatment Planning	Does the consumer feel involved in treatment decisions?	65%
Outcomes (of services)	Has the consumer experienced improvement in work, housing, and relationships?	55%
Functioning	Has the consumer's overall well-being improved?	56%
Social Connectedness	Does the consumer feel connected to friends, family, and community?	56%

* The fiscal year 2015 survey was conducted from March to September 2015.
** Proportions indicate respondents who chose answer choices "strongly agree" or "agree" rather than "neutral," disagree," or "strongly disagree."

Domain agreement rates did not differ substantially between fiscal year 2014 and fiscal year 2015.

Mental Health Statistics Program Inpatient Consumer Survey

Purpose

State psychiatric hospitals located throughout Texas serve people with psychiatric disorders who need services provided in a residential environment. The usual length of stay for civil patients, accounting for about one half of the patients in state hospitals, is short. Civil patients usually are treated for a few days or possibly weeks; the focus of services is stabilization and support of patients' return to the community. Forensic patients generally have a longer length of stay, which is determined by the court, and can vary from about 70 days, for patient on initial restoration commitment, to years for patient commitment under the Not Guilty by Reason of Insanity

commitment. State psychiatric hospitals provide assessment, evaluation, and treatment. Treatment involves a variety of services: psychiatry, nursing, social work, psychology, education/rehabilitation, nutrition, medical, and dental. These services are paid for through general revenue funds from the State of Texas, private payment, private third party insurance, and Medicare and Medicaid programs.

DSHS conducts the Inpatient Consumer Survey (ICS) in compliance with Mental Health Statistics Improvement Program (MHSIP) requirements. The ICS was distributed to every individual age 13 years old or older who was discharged from one of the ten state psychiatric hospitals in fiscal year 2014 and fiscal year 2015. The purpose of this survey was to measure individuals':

- Experience in the state psychiatric hospital, including their experience with staff, treatment, and the facility
- Participation in their treatment
- Ability to function after leaving the hospital

Sample and Methods

This is an ongoing survey that started more than seven years ago. The data reported currently are from fiscal years 2014 and 2015 (September 2013 to August 2015). These data were compared to the results from fiscal years 2012 and 2013. During fiscal years 2014 and 2015 combined, there were 21,103 discharges. The response rate varies widely according to setting. Patients in facilities with longer lengths of stay (especially forensic facilities) and more planned discharges have much higher response rates than civil facilities where patients leave very quickly and are often discharged by court leaving the day of court decision. Averaging all of these facilities, the response rate has been between 31 and 33 percent over the past four years.

The survey population was adolescents and adults served in the state psychiatric hospitals. Data were collected at ten state psychiatric hospitals:

- Austin State Hospital
- Big Spring State Hospital
- El Paso Psychiatric Center
- Kerrville State Hospital
- Rio Grande State Center
- Rusk State Hospital
- San Antonio State Hospital
- Terrell State Hospital
- North Texas State Hospital
- Waco Center for Youth

The ICS was conducted using a convenience sampling method. When a decision was made to discharge a patient, the patient was given an opportunity to complete the survey. This process could begin as early as three or more days prior to discharge. Patients could also be given an envelope so that the completed survey could be mailed back to the quality assurance division of the facility after discharge. The likelihood of a returned survey is greater prior to the customer

leaving the facility. Patients with hospital episodes greater than one year were given a survey to complete during each annual review. The survey was offered on paper, and was available in English and Spanish.

The total number of surveys received is an estimate due to the fact that not all facilities participate in all of the domains and duplicate surveys are removed at multiple points in the process. In fiscal year 2014, approximately 3,505 surveys were collected, and in fiscal year 2015, approximately 3,251 surveys were collected.

The survey includes questions about five topics, or domains, as shown in Table 21 below.

Table 21. Domains Measured in Mental Health Statistics Improvement Program Inpatient Customer Survey

Domain	Description of Domain
Outcome	Effect of the hospital stay on the customer's ability to deal with their illness and with social situations
Dignity	Quality of interactions between staff and customers that highlight a respectful relationship
Rights	Ability of customers to express disapproval with conditions or treatment and receive an appropriate response from the organization
Participation in Treatment	Customers' involvement in their hospital treatment as well as coordination with the customers' doctor or therapist from the community
Facility Environment	Feeling safe in the facility and the aesthetics of the facility

Major Findings

Overall, high-level monitoring of adolescent and adult satisfaction with state psychiatric hospitals uses an average overall score, which encompasses answers to survey questions in all five domains. In both fiscal year 2014 and 2015, this annual average score target was exceeded by all ten state psychiatric hospitals and showed little change from the scores in fiscal years 2012 and 2013. Across all four years, areas of strengths and weaknesses remained fairly consistent. When the five domains are compared, patients were slightly less satisfied with facility environment, which may be reflective of the older buildings the hospitals are utilizing. Another issue often cited by patients regarding their environment involves a lack of optimal privacy as structure of the buildings necessitates that patients have one to three roommates. Patients' rights also has a slightly lower score than the other domains and this typically reflects the high number of patients receiving treatment by court order and dynamics related to involuntary hospitalization. Results for fiscal years 2014 and 2015 are provided in Table 22.

Table 22. Mental Health Statistics Improvement Program Inpatient Customer Survey: Positive Responses to Domains

Domain	Fiscal Year 2014* Proportion of Respondents** (N=3,505)***	Fiscal Year 2015* Proportion of Respondents** (N=3,251)***
Outcome	78.0%	76.6%
Dignity	82.9%	80.8%
Rights	68.6%	67.5%
Participation in Treatment	78.1%	80.9%
Facility Environment	66.3%	72.0%

* The fiscal year 2014 survey was conducted from September 2013 to August 2014. The fiscal year 2015 survey was conducted from September 2014 to August 2015.
** Each question in the ICS is evaluated on a Likert scale from strongly disagree to strongly agree. For purposes of computing averages, a number value is given to the qualities of the scale from 1 for strongly disagree to 5 for strongly agree. A client must respond to a minimum of 2 questions in a domain in order for an average rating to be computed for the domain. Since there are only 3 to 4 questions in a domain, missing values are not inserted when a client does not answer a question. When the average rating for the questions in the domain is greater than 3.5, the client is considered to have "responded positively" to the domain. The proportion of clients who responded positively to the domain is the percent of clients who responded positively out of all clients who responded to the domain.
*** Not all facilities ask questions for each domain. The N listed is the approximate number of surveys collected.

II. Regulatory Services

Regulatory Licensing Unit Customer Service Satisfaction Survey

Purpose

The Regulatory Licensing Unit serves businesses and facilities to maintain the health and safety of Texans. The types of businesses that are served include: retail stores that sell abusable volatile chemicals and bedding, asbestos, bottled water operators, drugs and medical devices, foods, emergency medical services/trauma systems, hazardous products, lead abatement, meat and poultry, milk and dairy, mold assessors and remediators, radiation, retail food and school food establishments, tanning, tattoo, body piercing, and youth camps.

The types of facilities that are served include: abortion; ambulatory surgical, birthing, and community mental health centers; emergency medical services and trauma systems, including stroke and trauma facilities; end-stage renal disease facilities; freestanding emergency medical care facilities; hospitals, including general and special hospitals; psychiatric and crisis

stabilization units; narcotic treatment clinics; seafood and aquatic life, which includes crabmeat and shellfish processing facilities; special care facilities; and substance abuse facilities.

The unit provides customer service to the businesses and facilities to assist in the completion of their initial and renewal licensing applications. The purpose of the survey was to measure customer satisfaction with the Regulatory Licensing Unit.

Sample and Methods

The fiscal year 2014 survey was conducted from September 2013 to August 2014. The fiscal year 2015 survey was conducted from September 2014 to August 2015. There were 122,569 individuals, businesses, and facilities licensed in fiscal years 2014 and 2015.

The survey was available online on the DSHS website and was offered in English. The survey was available to any user of the DSHS website.

In fiscal year 2014, there were 205 completed surveys. In fiscal year 2015, there were 354 completed surveys.

Major Findings

Overall, the majority of individuals completing the Regulatory Licensing Unit customer service satisfaction survey were satisfied with the level of customer service received. In the most recent survey year (fiscal year 2015), the survey results included:

- 90 percent of respondents found DSHS staff helpful, courteous, and knowledgeable.
- 80 percent of respondents found communicating with DSHS (via telephone, mail, or electronically) an efficient process.
- 78 percent of respondents found the DSHS website user-friendly and that it contains adequate information.
- 78 percent of respondents reported that their application was easy to file and was processed in a timely manner.
- 81 percent of respondents found the forms, instructions, and other information provided by DSHS helpful and easy to understand.

Regulatory Inspection Unit Customer Service Satisfaction Survey

Purpose

The Regulatory Inspection Unit protects consumer health and safety by ensuring compliance with state and federal law and rules regulated under DSHS. Activities performed by staff in the inspection unit include inspections, product and environmental sampling, complaint

investigations, and technical assistance. The entities inspected include: retail stores that sell abusable volatile chemicals and hazardous products; asbestos, environmental lead, and mold abatements; tanning; tattoo and body piercing; drugs and medical device manufacture/distributors; food manufacturers; food and drug salvagers; milk and dairy; radioactive materials; x-ray and mammography.

The purpose of the survey is to determine customer satisfaction of the regulated entities that interact with Inspections Unit staff and provide the regulated entities a mechanism for input into the inspections process. Additionally, the survey data and comments are used as a quality assurance tool by managers. The information is reviewed on a quarterly basis to identify trends that may lead to training opportunities for staff and/or regulated entities.

Sample and Methods

The survey is made available to all regulated entities that come in contact with an inspector. The survey is conducted online through Survey Monkey. The survey was made available on March 1, 2014 and has been perpetually listed for entities to complete. The link to the survey is printed on the back of inspectors' business cards. Inspectors are required to present their business card and credentials upon entering a firm. On average, the Inspection Unit conducts approximately 40,000 inspections annually. The survey is offered in English only. From March 1, 2014 through August 31, 2015, 277 surveys were completed.

Major Findings

Overall, the majority of individuals completing the Inspections Unit customer service satisfaction survey were satisfied with the level of customer service received. The survey results from March 1, 2014 through August 31, 2015 included the following:

- 99 percent of respondents reported the inspector introduced himself/herself and presented his/her credentials/ID before the inspection.
- 99 percent of respondents reported the purpose of the inspection was adequately described at the beginning of the inspection.
- 99 percent of respondents reported that the DSHS Inspector was prepared and well organized.
- 99 percent of respondents reported that the inspection was handled in a courteous and professional manner.
- 98 percent of respondents reported that the on-site inspection was completed in a reasonable amount of time and did not unduly interfere with the delivery of services.
- 98 percent of respondents reported the inspector clearly explained any applicable state or federal requirements, answered questions adequately, and/or referred them to an alternate source for the information.

- 98 percent reported that the inspector clearly explained their findings.
- 88 percent reported that if deficiencies, observations, or violations were found, the inspector clearly explained the timeframe and/or process for corrective action.
- 92 percent reported that they now have a better understanding or knowledge of state and/or federal requirements affecting their business.

Professional Licensing and Certification Customer Service Satisfaction Survey

Purpose

The Professional Licensing and Certification Unit (PLCU) issues licenses, certification, and other registrations of healthcare professionals, and ensures compliance with standards. The regulation of the unit's allied and mental health occupations is a means to protect and promote public health, safety, and welfare. The regulation is intended to ensure that consumers in Texas receive services from qualified and competent providers. PLCU administers the following programs under the authority of 11 independent boards: athletic trainers; audiologists and speech-language pathologists; professional counselors; dietitians; fitters and dispensers of hearing instruments; marriage and family therapists; medical physicists; midwives and midwife training programs; orthotists, prosthetists, and related facilities; sex offender treatment providers; and social workers. The remaining 12 programs are administered directly by PLCU: chemical dependency counselors; code enforcement officers; contact lens dispensers; massage therapists, massage therapy training programs, and massage therapy establishments; medical radiologic technologists and medical radiologic technology training programs; offender education programs and instructors; opticians; perfusionists; personal emergency response system providers; respiratory care practitioners; sanitarians; and dyslexia practitioners and therapists.

The survey measured customer satisfaction with PLCU services to licensees of the 23 regulatory programs. The licensing process provides application and license renewal services for individuals and facilities that apply for and hold a license in the above regulatory programs.

This report details results from the Division for Regulatory Services Professional Licensing and Certification Unit's Customer Service Satisfaction survey. The purpose of this survey was to serve as a customer feedback tool and provide a mechanism for users to resolve any concerns with staff.

Sample and Methods

The fiscal year 2014 survey was conducted from September 2013 to August 2014. The fiscal year 2015 survey was conducted from September 2014 to August 2015. There were 175,682 individuals, businesses, and facilities licensed in fiscal years 2014 and 2015.

The survey was available online on the DSHS website and was offered in English. The survey was available to any user of the DSHS website.

In fiscal year 2014, there were 330 completed surveys. In fiscal year 2015, there were 1,107 completed surveys.

Summary of Findings

Overall, the majority of individuals completing the PLCU customer service satisfaction survey were not satisfied with the level of customer service received. In the most recent survey year (fiscal year 2015), the survey results included:

- 51 percent of respondents found DSHS staff helpful, courteous, and knowledgeable.
- 37 percent of respondents found communicating with DSHS (via telephone, mail, or electronically) an efficient process.
- 49 percent of respondents found the DSHS website user-friendly and that it contains adequate information.
- 38 percent of respondents reported that their application was easy to file and was processed in a timely manner.
- 53 percent of respondents found the forms, instructions, and other information provided by DSHS helpful and easy to understand.

During fiscal years 2014 and 2015, the programs of the Professional Licensing and Certification Unit underwent significant change. In May 2014, the Sunset Advisory Commission released its staff report, which initially recommended the discontinuation of 11 of the unit's licensing programs, recommended the transfer of 11 additional licensing programs to the Texas Department of Licensing and Regulation (TDLR), and recommended abolishing 8 independent boards and reconstituting them as (TDLR) advisory committees. Ultimately, the Sunset Advisory Commission recommended in August 2014 to transfer four licensing programs to Texas Medical Board (TMB), to transfer 10 licensing programs to TDLR and abolish associated independent boards, and to discontinue 4 licensing programs. S.B. 202, 84th Legislature, Regular Session, 2015 put the final Sunset Advisory Commission recommendations into motion. Throughout the Sunset and legislative processes, stakeholders and affected parties voiced numerous concerns with the proposed changes and some of those concerns are reflected in the survey comments.

Staffing within the PLCU was also affected by the legislative recommendations and the uncertainty associated with the proposals. Senate Bill 202 did not provide for the direct transfer of DSHS staff to TMB and TDLR along with the program transfers, instead directing TMB and TDLR to hire new positions and to give consideration to DSHS staff in the hiring process. As a result, a number of staff within PLCU, including key managers and customer service personnel, secured other positions within state government or decided to retire. Due to the budgetary uncertainty associated with the Senate Bill 202 contingency rider, a hiring freeze was implemented. Although some PLCU positions were filled, many were not. It is not unusual to take six months to a year to fully train licensing and customer service personnel in the complexity of their job functions. Taken together, these circumstances resulted in a loss of

manpower, experience, knowledge, and leadership within PLCU, which may have impacted the survey results.

PLCU is a high-volume licensing operation. To provide context, 1,107 individuals completed the customer service survey in FY 2015. In that same year, the unit:

- Received 223,921 telephone calls
- Received 33,428 licensure applications
- Issued 68,210 renewed licenses
- Issued 20,488 initial and upgraded licenses
- Received 1,022 consumer complaints against license holders

Patient Quality Care Unit Customer Service Satisfaction Survey

Purpose

The Patient Quality Care Unit (PQCU) conducts compliance activities to determine adherence with applicable state and federal laws, rules, and regulations. PQCU staff investigate complaints and conduct inspections[20] regarding the performance of licensed and or certified individuals, providers, and health care facilities that operate in Texas. The following programs subject to the compliance activities include: hospitals, psychiatric hospitals, laboratories, rural health clinics. dialysis facilities, comprehensive outpatient rehabilitation facilities, outpatient physical therapy/speech pathology facilities, ambulatory surgical centers, freestanding emergency medical centers, birthing centers, portable x-ray facilities, special care facilities, abortion clinics, substance abuse facilities, narcotic treatment programs, emergency medical services (EMS) providers, and EMS education programs.

The purpose of the survey is to measure customer satisfaction with PQCU. The survey data and comments from respondents also provide important feedback to PQCU managers.

Sample and Methods

The fiscal year 2014 survey, conducted from September 1, 2013 to August 31, 2014, was the first survey year with a sufficient number of responses for analysis. The fiscal year 2015 survey was conducted from September 1, 2014 to August 31, 2015.

The survey was available online on the DSHS website. The survey link was provided by department staff to customers after the inspection or complaint investigation had been conducted onsite. The survey was offered in English.

[20] PQCU refers to the inspections as onsite surveys. To avoid confusion with the customer satisfaction surveys, in this report, these onsite surveys are referred to as inspections.

The total number of survey responses varied slightly, depending upon the question. In FY 2014, there were approximately 325 responses, and in FY 2015, there were 364 responses.

Major Findings

Overall, the majority of individuals, providers, and facilities completing the PQCU customer service satisfaction survey were satisfied with the level of customer service received. Survey respondents were asked to evaluate eight key survey statements. Table 23 has the percent of respondents who answered agreed or strongly agreed to each survey question.

Table 23. PQCU Customer Service Satisfaction Survey Findings: Agreed or Strongly Agreed

Question	Fiscal Year 2014* Proportion of Respondents** (N=325)	Fiscal Year 2015* Proportion of Respondents** (N=364)
The on-site survey process was explained clearly.	96.4%	95.7%
The on-site survey did not interfere with the delivery of care or services.	93.7%	93.9%
The on-site survey assisted in your understanding of the applicable state and federal requirements.	91.2%	94.2%
Deficiencies, if any, were explained clearly so that you understood what the problem was and why.	87.5%	90.0%
If deficiencies were found, the time frame and process for the plan of correction was explained.	84.6%	85.8%
The on-site survey was completed in a reasonable amount of time.	94.4%	92.4%
The on-site survey met your expectations.	94.7%	93.3%
The survey was conducted in a courteous, professional manner.	96.2%	95.8%

* The fiscal year 2014 survey was conducted from September 2013 to August 2014. The fiscal year 2015 survey was conducted from September 2014 to August 2015.
** Percentages indicate respondents who answered "strongly agree" or "agree" rather than "neutral," disagree," or "strongly disagree."

Adult Safety Net Provider Satisfaction Survey

Purpose

The Adult Safety Net (ASN) Program supplies publicly-purchased vaccines at no cost to enrolled providers. The program was created by the Texas Department of State Health Services (DSHS) Immunization Branch to increase access to vaccination services in Texas for uninsured adults, thereby raising the immunization coverage levels and improving the health of Texans.

The purpose of the ASN Provider Satisfaction Survey, which was distributed to health care providers registered with the ASN program, was to assess these providers' overall satisfaction with the program, the vaccine ordering process, site visits, customer service, communication, training, and ImmTrac, the Texas Immunization Registry. The survey was conducted by the DSHS Immunization Branch. The study population was all ASN providers.

Sample and Methods

The study sought responses from all ASN providers and was conducted via a QuestionPro online survey from November 5, 2014, to December 11, 2014. The survey was offered in English only. Individuals provided responses on behalf of their clinics/practices by filling out the online survey. The total number of completed responses was 230 out of 503 for a response rate of 46 percent.

Major Findings

The major findings of the ASN provider satisfaction survey were as follows:

- Overall, 96 percent of respondents indicated that they would recommend enrollment in the ASN program to other colleagues/providers based on their experience.
- 91 percent of respondents indicated that they either strongly agreed or agreed that the ASN program was beneficial to their practice/clinic and patients.
- The majority of respondents demonstrated overall satisfaction with customer service and support provided by program staff, as well as information and materials provided by the program.
- Three components of the ASN program indicated less than satisfactory scores below 80 percent. Those three questions were related to the available range of vaccine choices (78 percent) the process for returning vaccines (74 percent), and fax updates (79 percent).

- The results of the full survey are shown below. The percentages in Table 24 indicate for each question the percentage of respondents who agreed with the statement or were satisfied with service.[1]

Table 24. ASN Provider Survey Overall Satisfaction Findings: Indicated Strongly Agreed, Agreed, Very Satisfied, or Satisfied*

Satisfaction Measure	Proportion of Respondents Satisfied** (N=203)
Overall satisfaction with ASN program	87%
Client would recommend other colleagues/providers enroll as an ASN provider	96%
ASN vaccine ordering process through the Electronic Vaccine Inventory (EVI) system	93%
Belief that the ASN program is beneficial to practice/clinic and patients	91%
The available range of vaccine choices	78%
The availability of requested vaccines	86%
The timeliness of ASN vaccine deliveries	85%
Belief that participation in the ASN program has improved immunization coverage levels	86%
The condition of ASN vaccines upon arrival	97%
The process for returning vaccines	74%
The process of screening patients for ASN eligibility	86%
The ASN program reporting requirements	88%
The process of maintaining ASN records	89%
The quality of available educational materials related to the ASN program	88%
The overall customer service provided by ASN staff	93%
The support, information, and materials provided by ASN staff	93%
The courtesy and professionalism of ASN staff	93%
The ability of ASN staff to understand and address needs	91%

Satisfaction Measure	Proportion of Respondents Satisfied** (N=203)
E-mail updates	94%
Fax updates	79%
ASN website	84%
DSHS vaccine call center	85%

*The survey was conducted from November 5, 2014, to December 11, 2014.
**Proportions indicate respondents who chose responses "strongly agreed," "agreed," "very satisfied," "satisfied," or "yes" rather than "disagree," "strongly disagree," "dissatisfied," or "very dissatisfied." Those who did not answer the survey question are not counted in these proportions.

Texas Vaccines for Children Provider Satisfaction Survey

Purpose

The Texas Vaccines for Children (TVFC) program guarantees vaccines are available at no cost to health care providers, in order to immunize children (birth - 18 years of age) who meet the eligibility requirements. The following groups of children are eligible to receive immunizations through the TVFC program: uninsured or underinsured children, children who are covered by CHIP, children who are of Native American or Native Alaskan heritage, and children on Medicaid.

The purpose of the TVFC Provider Satisfaction Survey, which was distributed to health care providers registered with the TVFC program, was to assess these providers' overall satisfaction with the program, the vaccine ordering process, site visits, customer service, communication, training, and ImmTrac, the Texas Immunization Registry. The survey was conducted by the DSHS Immunization Branch.

Sample and Methods

The study sought responses from all TVFC providers and was conducted via a QuestionPro online survey from August 6, 2014, to August 25, 2014. The survey was offered in English only. Individuals provided responses on behalf of their clinics/practices by filling out the online survey. The total number of completed responses was 1,025 out of 3,400 for a response rate of 30 percent.

Major Findings

TVFC Program Findings:

- Overall, 95 percent of respondents indicated that they would recommend enrollment in the TVFC program to other colleagues/providers based on their experience.
- 95 percent of respondents indicated that they either strongly agreed or agreed that the TVFC program was beneficial to their practice/clinic and patients.
- 93 percent of providers surveyed responded that they provide all Advisory Committee on Immunization Practices (ACIP) recommended vaccines.
- The majority of respondents demonstrated overall satisfaction with customer service and support provided by TVFC staff as well as information and materials provided by the program.
- Two components of the TVFC program indicated less than satisfactory scores below 80 percent. Those two questions were related to timeliness of vaccine delivery (75 percent) and the process for returning vaccines (67 percent). Several open-ended comments expressed frustration with difficulty and complexity of the process for returning vaccines.
- Table 25 provides the full survey results.

Table 25. TVFC Provider Survey Overall Satisfaction Findings: Indicated Strongly Agreed, Agreed, Very Satisfied, or Satisfied*

Satisfaction Measure	Proportion of Respondents Satisfied** (N=1,025)
The condition of TVFC vaccines upon arrival	96%
Client would recommend other colleagues/providers enroll as a TVFC provider	95%
Belief that TVFC program is beneficial to practice/clinic and patients	95%
The available range of vaccine choices	93%
TVFC e-mail updates	92%
Belief that participation in the TVFC program has improved immunization coverage levels	91%
The courtesy and professionalism of TVFC staff	90%
The support, information, and materials provided by TVFC staff	89%

Satisfaction Measure	Proportion of Respondents Satisfied** (N=1,025)
The TVFC website	88%
The overall customer service provided by TVFC staff	88%
The ability of TVFC staff to understand and address needs	87%
The quality of available educational materials related to the TVFC program	87%
Regional DSHS contact	87%
The availability of requested vaccines	86%
The quality of TVFC required training (e.g., vaccine storage and handling)	86%
Overall satisfaction with TVFC program	85%
The TFVC vaccine ordering process through the Electronic Vaccine Inventory (EVI) System	85%
TVFC vaccine call center	85%
The process of maintaining TVFC records	83%
TVFC compliance site visits	83%
TVFC fax updates	83%
The TVFC program reporting requirements	82%
The process of screening patients for TVFC eligibility	81%
The timeliness of TVFC vaccine deliveries	75%
The process for returning vaccines	67%

*The survey was conducted from August 6, 2014, to August 25, 2014.
**Proportions indicate respondents who chose responses "strongly agreed," "agreed," "very satisfied", "satisfied", or "yes" rather than "disagree," "strongly disagree," "dissatisfied," or "very dissatisfied." Those who did not answer the survey question are not counted in these proportions.

ImmTrac Findings:

- 92 percent of respondents agreed or strongly agreed that ImmTrac is useful.
- 83 percent of respondents were satisfied or very satisfied with ImmTrac quality of data.
- 82 percent of respondents were satisfied or very satisfied with ImmTrac customer support.

- ImmTrac-related questions that had satisfaction scores (satisfied or very satisfied) below 80 percent concerned training offered for ImmTrac (76 percent) and reminder/recall functions (75 percent). 73 percent of respondents also said they were not aware of the meaningful use functionality in ImmTrac.

IV. Specialized Health Services

Case Management for Children and Pregnant Woman Provider Survey

Purpose

The Case Management for Children and Pregnant Woman program serves children birth through age 20 and pregnant woman of any age who are Medicaid eligible. The program provides assistance in gaining access to necessary medical, social, education, and other service needs related to the health condition or health risk and/or high-risk pregnancy. Case Management services are provided to eligible clients by case managers who are approved through DSHS and enrolled in Medicaid.

The purpose of the survey was to obtain information regarding 1) the prior authorization process from case managers who provide case management services to eligible clients and 2) the communication strategies for relaying the prior authorization information to the case manager.

The survey was conducted by DSHS staff with assistance from the Office of Program Decision and Support to ensure survey questions were worded effectively for statistical significance.

The study population was active, inactive, and closed case management providers. Active providers are providers who are presently accepting new referrals; inactive providers are not presently accepting new referrals, but may in the future; closed provider are providers who are not accepting new referrals and will not be in the future.

Sample and Methods

DSHS staff that provide oversight to the Case Management for Children and Pregnant Women program keep a database of providers of the program and their contact information. All providers in the database were sent a survey link based on their status (active, inactive, closed). Only providers who previously stated they did not want correspondence were not sent the survey.

The study was emailed to providers in June 2015 and was conducted by online surveys using Question Pro. The surveys were offered in English only.

Individuals provided their responses by completing the survey themselves.

Surveys were started by 62 active providers, 20 inactive providers, and 66 closed providers, for a total of 148 surveys, however many respondents did not answer all of the survey questions. The survey was sent to 679 providers: 100 active providers, 38 inactive providers, and 541 closed

providers. The total response rate is 14 percent. The response rate for active providers is 49 percent, for inactive providers it is 31.5 percent, and for closed providers it is less than 1 percent.

Major Findings

The survey responses indicate that the prior authorization process is functioning well for its intended purpose. The majority of respondents thought the amount of training provided is helpful and just the right amount. Most providers submit prior authorizations for children and a third of these respondents feel as though the number of visits approved is appropriate. Communication from DSHS central office staff is timely and appropriate. Email is the preferred communication method for providers and most providers would prefer all documentation/prior authorization information be electronic. The number of responses varies by question since not all respondents answered all of the questions.

Prior Authorization Process Findings:

- When asked if the documentation needed for prior authorization is clear and easy to complete, 51 percent of respondents answered yes and 23 percent answered sometimes. (N = 109)
- When asked if obtaining approval for pregnant women is more difficult than obtaining approval for children, 27 percent of respondents answered yes, 7 percent answered sometimes, and 46 percent answered that they were uncertain. (N = 107) The large number of providers who are uncertain if obtaining approval for pregnant woman is more difficult is not unexpected since 60 percent of respondents had not submitted any prior authorizations for pregnant women in the past year. (N = 124)
- When asked if the number of initial case management visits approved for children and youth with special health care needs is appropriate to meet their initial needs, 33 percent of respondents answered yes, 23 percent answered sometimes, and 23 percent answered that they were uncertain. (N = 99)
- When asked what changes to the prior authorization service would be helpful, the most popular answer was making the documentation requirements easier to complete and less time consuming.
- 46 percent of respondents thought the prior authorization training was very helpful and 29 percent thought it was fairly helpful. 67 percent of respondents thought the amount of training was just right. (N = 94)

Communication Findings:

- 70 percent of respondents reported that the DSHS central office staff are timely in prior authorization feedback. (N = 96)
- 61 percent of respondents reported that the amount of communication from the central office is appropriate. (N = 95)

- 79 percent of respondents prefer DSHS central staff to contact them via email to clarify information or provide feedback on a prior authorization.
- The survey also asked how respondents would like the central office to communicate with them in general. The most popular answer was email.
- Electronic communication was a common theme in comment fields. Currently, the prior authorization responses are faxed to providers after DSHS central office review them. Seven providers wrote that emailing responses or making it all online or electronic would be preferable than receiving responses via fax.

Kidney Health Care Program Client Satisfaction Survey

Purpose

The Kidney Health Care Program (KHC) serves Texas residents who have a diagnosis of end-stage renal disease (ESRD) and an annual income of less than $60,000. Primary benefits include payment for limited ESRD related medical services including dialysis and access surgery, assistance with allowable drugs and Medicare premiums, and travel for ESRD related services. Benefits are dependent on the client's treatment status and their eligibility for benefits from other payer sources, including Medicare, Medicaid, and private insurance.

The Purchased Health Services Unit (PHSU) interacts with dialysis and transplant hospital social workers routinely. Social workers at contracted dialysis facilities play an important role assisting clients diagnosed with ESRD in applying for and accessing available services and benefits. They do this by providing assistance with obtaining access to resources that can help pay for medical and travel benefits related to ESRD. Social workers expedite enrollment in KHC and assist clients with enrollment in Medicare and Medicaid. Social workers also track and submit their travel claims when eligible for travel benefits from the program.

The survey was developed as an internal quality assurance project with the purpose of assessing client satisfaction with program services provided directly by PHSU and contractor staff for the program, and to identify areas for improvement. PHSU wanted to assess:

- The quality of customer service being provided over the telephone
- How social workers help clients
- Overall satisfaction with the program from clients receiving services
- Which services are viewed as the most valuable to clients
- How clients prefer to receive information from the program

KHC developed and conducted the survey. The study population included all KHC clients who received a program benefit prior to or during October or November of 2013.

Sample and Methods

The survey sought responses from KHC clients that had received an Explanation of Benefits (EOB) for services, in October or November 2013. An EOB statement is a document that is provided to program clients after they have submitted a claim or a claim was submitted on their behalf. The number of clients receiving EOBs in October was 13,044 and in November it was 12,672. KHC staff mailed written surveys to the 25,716 clients identified and gave instructions that the survey could also be completed online. The survey was administered October through December 2013.

The surveys were available in English and Spanish. Individuals provided their responses by returning the written survey or by completing an online survey that was made available on the KHC website.

Not all respondents answered every question in the survey, and some answered questions unintended to be answered based on a previous response. Therefore, data calculations were only based on the number of actual responses received for a given question filtered as appropriate based on the previous response. The number and percentage associated with each response was calculated. No weights are applied.

The total number of completed responses was 1,119 out of 25,716 resulting in a 4 percent response rate.

Major Findings

Customer Service

The survey responses were generally favorable. The 268 clients (24 percent) who had contacted the program in the previous 12 months expressed overall satisfaction with customer service.

• 87 percent reported that KHC staff was knowledgeable.

• 89 percent reported that KHC staff was able to take care of concerns at the time of their call.

• Only 13 of the 268 respondents (5 percent) reported that KHC staff was not able to take care of their concerns at the time of their call.

Data analysis revealed that clients do not have a clear understanding of KHC benefits. Feedback reveals that clients may confuse KHC with the Kidney Foundation, with the ESRD Network, or with their dialysis facility. In response to these data, KHC is considering an annual newsletter and a "tip of the month" to include in EOBs. Additionally, the client handbook has been scheduled for revision in English and Spanish.

Social Work Services

Clients were asked how often they talked to their social worker in the past year. They were also asked how their social worker helped them, and could choose from a variety of responses.

Finally, respondents were asked if their social worker presented the information in a clear and understandable way.

Respondents were then asked to describe how their social worker helps them with their healthcare needs by selecting from any number of items in a list, or free-writing other ways that their social worker helped them. Of 976 respondents who answered this question, 80 percent said that their social worker helps them by submitting their mileage to KHC for travel reimbursement and 69 percent said they help by explaining the benefits of KHC. Table 26 illustrates the ways in which social workers assist KHC clients.

Table 26. Number of Respondents Selecting from a Pre-defined List of Ways Social Workers Help Them*

Ways in Which Social Workers Help	Number of Respondents who Selected Each Option	Percent of Respondents who Selected Each Option
Submitting mileage for reimbursement	777	80%
Explaining the benefits of KHC Program	675	69%
Helping me choose a Medicare Part D Plan	366	38%
Helping me get supplies and equipment	352	36%
Helping with doctor visits	257	26%
Helping me get access surgery (shunt, fistula)	245	25%
Helping me get rides to appointments/dialysis	234	24%

* The survey was conducted October through December 2013.

Women, Infants, and Children Nutrition Education Survey

Purpose

Special Supplemental Program for Women, Infants, and Children (WIC) is a federally funded, state-administered program that serves low income women, infants, and children up to the age of five that are at nutritional risk. Part of the program includes federally mandated nutrition education that is provided by local agencies that are contracted with the state.

The WIC Nutrition Education Survey, administered every two years, collects responses from adult WIC clients. Clients responded to 27 questions examining their preferences for nutrition education and opinions about WIC, technology usage, self-efficacy for healthy lifestyle habits, and demographics. The survey helps the state WIC program and local contractors assess customer satisfaction and improve their nutrition classes.

The 2014 full report is available at: http://www.dshs.state.tx.us/wichd/nut/nesurveyresults.shtm.

Sample and Methods

The WIC nutrition education survey is conducted every two years. The latest implementation was conducted in April 2014. There were 3,405 completed surveys (95 percent response rate).

Each local agency that contracts with the state to provide WIC nutrition education classes was provided with paper surveys and was asked to return a designated number of surveys calculated based on their number of clients. The contractors distributed the surveys in paper format in person with the WIC clients using a convenience sample. The survey was offered in English and Spanish. Participants were offered nutrition class credit as an incentive for completion of the survey.

Summary of Findings

The results of the survey indicate that clients had favorable opinions about the WIC program's ability to meet their needs and high customer satisfaction. Clients rated their agreement with the following statements about their last WIC nutrition group class as shown in Table 27.

Table 27. Women, Infants, and Children Program Nutrition Education Survey - Group Class: Indicated Strongly Agreed or Agreed*

Survey Question	Proportion of Respondents** (N=3,405)
WIC classes are offered at a good time of day	97.1%
WIC classes are too long	23.1%
WIC classes cover topics I am interested in	95.4%
I like learning in a group in WIC classes	82.8%
I have a hard time finding transportation to get to classes at WIC	22.5%
It is worth my time and effort to come to classes at WIC	93.8%

*The survey was conducted in April 2014.
**The percentages presented in the table are the proportion of respondents presented who gave the response "strongly agree" or "agree" as opposed to "disagree" or "strongly disagree."

Clients rated the following statements about their WIC clinic as shown in Table 28.

Table 28. Women, Infants, and Children Program Nutrition Education Survey - WIC Clinic: Indicated Strongly Agreed or Agreed*

Survey Question	Proportion of Respondents** (N=3,405)
WIC 'gets' (understands) me	97.1%
WIC staff respect me	98.9%
WIC staff are friendly	98.5%
WIC staff talk about what I want to talk about	97.9%
When I have a question about nutrition, WIC staff can answer it	99.4%
When I have a question about breastfeeding, WIC staff can answer it	98.5%
The benefits of the WIC program are worth my time and effort	99.1%

**The survey was conducted in April 2014.
**The percentages presented in the table are the proportion of respondents presented who gave the response "strongly agree" or "agree" as opposed to "disagree" or "strongly disagree."

Laboratory Services Courier Program Satisfaction Survey

Purpose

The DSHS Laboratory Courier Program offers overnight courier services via LoneStar Delivery and Process (LSDP) to facilities across the state. This allows the lab to get specimens sooner to begin testing in a timelier manner. The program serves specific sites in Texas that submit clinical specimens to the lab for testing.

The purpose of the survey was to gauge the satisfaction of current courier customers. The survey was conducted by the courier program coordinator. The study population was all sites that used services in 2014.

Sample and Methods

The study sought responses from all sites that are enrolled in the courier program and was conducted by paper and online surveys from August 1, 2014 – August 31, 2014. The surveys were offered in English only. Individuals provided their responses by completing survey themselves. The total number of completed responses was 156 out of 434 for a response rate of 36 percent.

Major Findings

The survey results show that 73 percent of all respondents were highly satisfied with the courier service and 16 percent of respondents were somewhat satisfied. Respondents were also asked to rate the courier program on the following attributes: customer service experience, professionalism, quality of service, and understanding customer needs. For all four attributes, more than 80 percent of respondents rated the program as above average or well above average. Despite the positive ratings, the survey responses had both positive and negative comments about the program. All negative responses were followed up on if contact information was provided. All comments, positive and negative, were passed on to LSDP for self-evaluation.

Seven surveys captured customer satisfaction information from Texas Health and Human Services Commission (HHSC) customers since the 2014 report. The surveys summarized in this chapter were administered in fiscal years 2014 and 2015.

For readability, this chapter is organized in three sections:

I. Children's Healthcare Coverage

II. Adult Healthcare Coverage

III. Self-Service Portal for Benefits Enrollment

The first six of the seven surveys discussed here relate to Medicaid or Texas Children's Health Insurance Program (CHIP) services and were conducted by the Institute for Child Health Policy (ICHP) at the University of Florida. Federal law requires state Medicaid programs to contract with an external quality review organization to help evaluate services. HHSC contracts with ICHP for this purpose. The surveys, which capture members' perceptions about and experiences of health, dental, or behavioral health services, are conducted on a recurring basis. The questions on the surveys are primarily taken from validated and nationally used survey instruments.

HHSC's Strategic Decision Support unit conducted the additional survey discussed in this chapter regarding customer satisfaction with the benefits enrollment self-service portal.

I. Children's Healthcare Coverage

The surveys about services for children include:

- STAR Child Caregiver Member Survey
- CHIP Caregiver Member Survey
- Medicaid and CHIP Dental Caregiver Survey
- STAR Health Caregiver Member Survey

ICHP used a similar survey protocol for all four surveys. Evaluators sent advance notification letters written in English and Spanish to caregivers of member children in Medicaid and CHIP requesting their participation in the surveys. Then the evaluators telephoned caregivers seven days a week in both day-time and evening hours (generally between 9:00 a.m. and 9:00 p.m. Central Time) to complete the survey. Multiple attempts (up to 20 for most programs) were made to reach a family before a member's phone number was removed from the calling circuit. If a respondent was unable to complete the interview in English, evaluators referred the respondent to a Spanish-speaking interviewer for a later time.

The survey was conducted by the University of Florida Survey Research Center (UFSRC) and included questions from the following sources:

- The Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, a widely used instrument for measuring and reporting consumer experiences with their health plan and providers.
- Items developed by ICHP pertaining to caregiver and member demographic and household characteristics

The CAHPS® items include overall ratings on a 10-point scale for each caregiver's assessment of services regarding the child's health care, personal doctor, specialist, and health plan.

STAR Child Caregiver Member Survey

Purpose

ICHP conducted the STAR Child Caregiver Member Survey between May 2015 and August 2015 with caregivers of children who received services funded through the Medicaid STAR program. STAR serves children in low-income families as well as adults who meet certain income and eligibility criteria. The program provides physical and behavioral health services and dental services for children. A separate dental member survey was also conducted. Surveys for adults and children in the STAR program were conducted separately.

The purpose of the STAR child caregiver member survey is to determine the sociodemographic characteristics and health status of children enrolled in the Texas Medicaid STAR Program and to assess parental experiences and satisfaction with health care received by STAR enrollees. Additionally, the survey included questions to address the need for and availability of specialized services for enrollees and healthcare needs as children with chronic conditions transition into adulthood.

Sample and Methods

Participants for the STAR Child Caregiver Member Survey were selected from a stratified random sample of beneficiaries ages 17 years or younger who were enrolled in STAR for six continuous months between September 2014 to February 2015. Members having no more than one 30-day break in enrollment in the same managed care organization (MCO) during this period were included in the sample. The sample was stratified to include representation from the 45 plan codes (MCO/service areas), with a target number of 200 completed surveys per quota. The sample was drawn from the beneficiaries (children) but the survey was conducted with their parents/caregivers. The survey was conducted from May to August 2015.There were 4,148 completed surveys.[21] The response rate was 32 percent, and the cooperation rate was 57 percent.[22]

[21] This includes results for the long form survey only.

[22] The response rate represents the number of completed or partially completed surveys divided by the number of verified, eligible households that could be contacted. The cooperation rate represents the number of completed or partially competed surveys divided by the number of members who either participated or refused.

Major Findings

ICHP presented the findings to HHSC for a number of domains (e.g., how well doctors communicate, customer services, and getting care quickly). The scores in Tables 29 and 30 are presented as composites, which are scores that combine results for closely related survey items (e.g., five questions related to getting care quickly).[23]

Table 29. STAR Child Caregiver Member Survey CAHPS® Composites: Percent "Always" Having Positive Experiences*

Satisfaction Measure	Proportion of Respondents (N=4,148)
Getting Needed Care	61.7%
Getting Care Quickly	76.5%
How Well Doctors Communicate	79.2%
Customer Service	78.3%
Shared Decision Making	76.9%
Access to Specialized Services	56.6%
Personal Doctor	87.7%
Coordination of Care	77.9%
Getting Needed Information	76.0%
Getting Prescriptions	75.4%

* The survey was conducted from May to August 2015.

[23] CAHPS® composite rates and CAHPS®-based HHSC Dashboard indicators in this report are calculated following the "top box" (percent always) method. This differs from the scoring method used in prior years (percent usually + always); therefore, results in this file should not be compared to those in the prior-year report due to changes in the scoring methodology.

Table 30. STAR Child Caregiver Member Survey CAHPS® Ratings: Percent Rating at "9" or "10"*

Satisfaction Measure	Proportion of Respondents (N=4,148)
Health Care Rating	72.7%
Personal Doctor Rating	76.1%
Specialist Rating	77.9%
Health Plan Rating	81.3%

* The survey was conducted from May to August 2015.

HHSC also set benchmarks (HHSC performance dashboard indicators) for the agency's performance in several key domains, and the relevant results of the STAR child caregiver member survey are also reported relative to these performance indicator benchmarks in Table 31.

Table 31. Statewide STAR Child CAHPS® Member Survey Results Relative to HHSC Performance Dashboard Indicators*

Performance Dashboard Indicator	STAR Child Survey Results (N=4,148)	STAR Dashboard Standard (2015)
Good access to urgent care	78.8%	83%
Good access to specialist referral	58.3%	53%
Good access to routine care	74.3%	73%
Good access to behavioral health treatment or counseling	57.0%	54%
Members rating child's personal doctor "9" or "10"	76.1%	77%
Members rating child's health plan a "9" or "10"	81.3%	81%
Good experience with doctor's communication	79.2%	80%

* The survey was conducted from May to August 2015.

CHIP Caregiver Member Survey

Purpose

ICHP conducted the member surveys between May 2015 and August 2015 with caregivers of children who received services funded through the CHIP program. CHIP is a partially subsidized health insurance program for children from families whose income falls below a specific threshold but exceeds the eligibility level to qualify for Medicaid.

The intent of the CHIP Caregiver Member Survey is to determine the sociodemographic characteristics and health status of children enrolled in Texas CHIP and to assess parental experiences and satisfaction with health care received by CHIP enrollees. Additionally, the survey included questions to address the need for and availability of specialized services for members and healthcare needs as children with chronic conditions transition into adulthood.

Sample and Methods

Participants for the CHIP caregiver member survey were selected from a stratified random sample of beneficiaries ages 17 years or younger who were enrolled in CHIP for six continuous months between September 2014 to February 2015. Members having no more than one 30-day break in enrollment in the same MCO during this period were included in the sample. The sample was stratified to include representation from the 33 plan codes (MCO/service areas), with a target number of 200 completed surveys per quota. The survey was conducted from May to August 2015.

There were 3,689[24] completed surveys. The response rate was 30 percent, and the cooperation rate was 63 percent.

Major Findings

ICHP presented the findings to HHSC for a number of domains (e.g., how well doctors communicate, customer services, and getting care quickly). The scores in Tables 32 and 33 are presented as composites, which are scores that combine results for closely related survey items (e.g., five questions related to getting care quickly).

[24] This includes results for the long form survey only.

Table 32. CHIP Caregiver Member Survey CAHPS® Composites: Percent "Always" Having Positive Experiences*

Satisfaction Measure	Proportion of Respondents (N=3,689)
Getting Needed Care	55.4%
Getting Care Quickly	72.7%
How Well Doctors Communicate	78.2%
Customer Service	74.6%
Shared Decision Making	74.4%
Access to Specialized Services	47.1%
Personal Doctor	89.5%
Coordination of Care	71.6%
Getting Needed Information	72.7%
Getting Prescriptions	75.9%

* The survey was conducted from May to August 2015.

Table 33. CHIP Caregiver Member Survey CAHPS® Ratings: Percent Rating at "9" or "10"*

Satisfaction Measure	Proportion of Respondents (N=3,689)
Health Care Rating	69.8%
Personal Doctor Rating	73.3%
Specialist Rating	72.0%
Health Plan Rating	73.3%

* The survey was conducted from May to August 2015.

HHSC also set benchmarks (HHSC performance dashboard indicators) for the agency's performance in several key domains, and the relevant results of the CHIP caregiver member survey are also reported relative to these performance indicator benchmarks in Table 34.

Table 34. Statewide CHIP Established Enrollee Survey Results Relative to HHSC Performance Dashboard Indicators*

Performance Dashboard Indicator	CHIP Survey Results (N=3,689)	CHIP Dashboard Standard (2015)
Good access to urgent care	74.9%	78.0%
Good access to specialist appointments	50.4%	53.0%
Good access to routine care	70.5%	75.0%
Good access to behavioral health treatment or counseling	39.5%	49.0%
Members rating child's personal doctor "9" or "10"	73.3%	72.0%
Members rating child's health plan a "9" or "10"	73.3%	72.0%
Good experience with doctor's communication	78.2%	78.0%

* The survey was conducted from May to August 2015.

Medicaid and CHIP Dental Caregiver Survey

Purpose

The intent of the Medicaid and CHIP Dental Caregiver Survey is to assess caregivers' experiences and satisfaction with the dental health services their children received in the Medicaid and CHIP programs.

The survey included the CAHPS® Dental Plan Survey, adapted to a child population. The CAHPS® dental plan survey is designed to gather information from Medicaid and CHIP beneficiaries' caregivers about the dental care experiences of their child. Specifically, this survey included questions to address:

- The sociodemographic characteristics and health status of child enrollees receiving dental health services.
- Caregiver experiences and satisfaction with their child's dentist and dental services overall, and as it pertains to:
    - The timeliness of getting treatment
    - The quality of dentist's communication and care

- Getting treatment and information from the health plan
- Receiving information about treatment options

Sample and Methods

A stratified random sample of members was selected for this survey. The sample was stratified by program and MCO, resulting in four sampling groups:

- Children age 17 years and younger enrolled in STAR DentaQuest
- Children age 17 years and younger enrolled in STAR MCNA Dental
- Children age 17 years and younger enrolled in CHIP DentaQuest
- Children age 17 years and younger enrolled in CHIP MCNA Dental

The survey was conducted between June 2015 and September 2015. Caregivers of members were asked about services received between December 2014 and September 2015.

A total of 1,204 caregivers participated in the survey, distributed among the quotas:

- STAR DentaQuest (N=300)
- STAR MCNA (N=302)
- CHIP DentaQuest (N=302)
- CHIP MCNA (N=300)

Major Findings

ICHP presented findings from the surveys to HHSC. Selected findings that relate to the four domains of care described in the methodology section are presented in Table 35. Selected findings related to access and overall satisfaction are presented in Table 36.

Table 35. Medicaid and CHIP Dental Caregiver Survey: Proportion of Respondents who Answered "Usually" or "Always"[*] [**]

Satisfaction Measure	Medicaid Dental (N=602)	CHIP Dental (N=602)
In the last six months, how often were your child's dental appointments as soon as you wanted?	92.7%	90.9%
In the last six months, how often did the customer service staff at your child's dental plan treat you with courtesy and respect?	97.0%	94.5%
In the last six months, how often did your child's regular dentist explain things in a way that was easy to understand?	92.9%	93.4%
In the last six months, how often did your child's dental plan cover all of the services you thought were covered?	93.9%	80.3%
[Of those who sought information] In the last six months, how often did the 800 number, written materials or website provide the information you wanted?	81.0%	76.2%

* The survey was conducted from June to September 2015.
**Possible answer choices were "never," "sometimes," "usually," "always," "don't know," and "refused." For these calculated percentages, only valid responses were included in the denominator; responses of "don't know" or "refused" were excluded.

Table 36. Medicaid and CHIP Dental Caregiver Survey: Proportion of Respondents who Answered "9" or "10"[*] [**]

Satisfaction Measure	Medicaid Dental (N=602)	CHIP Dental (N=602)
Using any number from 0 to 10, where 0 is extremely difficult and 10 is extremely easy, what number would you use to rate how easy it was for you to find a dentist for your child?	76.0%	70.0%
Using any number from 0 to 10, where 0 is the worst dental plan possible and 10 is the best dental plan possible, what number would you use to rate your child's dental plan?	82.2%	69.0%

* The survey was conducted from June to September 2015.
** For these calculated percentages, only valid responses were included in the denominator; responses of "don't know" or "refused" were excluded.

STAR Health Caregiver Survey

Purpose

In order to improve the coordination of care for children and adolescents in foster care, HHSC launched STAR Health in 2008. Superior HealthPlan is the MCO that provides medical and behavioral health, dental, vision, and pharmacy benefits to children and adolescents in STAR Health. Members receive services through a medical home (i.e., primary care doctor), expedited enrollment, and a 24-hour nurse hotline for caregivers and caseworkers, as well as service management provided by Superior. ICHP conducted member surveys between August 2014 and November 2014 with caregivers of children and adolescents in foster care who were enrolled in STAR Health.

The intent of the STAR Health Caregiver Survey:

- Describe the sociodemographic characteristics of the children and adolescents in foster care enrolled in STAR Health, as well as of their caregivers.
- Describe the health status of children and adolescents in STAR Health.
- Document caregivers' experiences and satisfaction with their children's health care.
- Use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) composites, caregiver ratings, and HHSC Performance Dashboard Indicators to evaluate the STAR Health program.
- Identify disparities in caregivers' experiences and satisfaction of care across member characteristics.
- Report on new measures, developed by ICHP in collaboration with HHSC, that assess caregivers' knowledge of and experiences with the Texas Health Steps program and with psychotropic medications for their children.

Sample and Methods

ICHP selected participants for the STAR health caregiver survey from a stratified random sample of beneficiaries age 17 years or younger who were enrolled in the STAR Health program for six continuous months between October and November 2014.

In addition to AHRQ CAHPS® survey items and items developed by ICHP pertaining to caregiver and member demographic and household characteristics, the STAR health caregiver survey also included items developed by ICHP in conjunction with HHSC pertaining to Texas HealthSteps and child psychotropic medication and behavioral health.

Attempts were made to contact caregivers of 2,041 children who were enrolled in STAR Health, with a target completion of 300 surveys. There were 301 completed surveys, for a response rate of 33 percent. The cooperation rate was 65 percent. The survey was conducted from August to November 2014.

Major Findings

ICHP presented the findings to HHSC for a number of domains (e.g., how well doctors communicate, customer services, and getting care quickly). The scores are presented as composites, which are scores that combine results for closely related survey items (e.g., five questions related to getting care quickly). Table 37 presents the composite scores and Table 38 presents the ratings for several questions.

Table 37. STAR Health Caregiver Survey CAHPS® Composites: Percent "Usually" or "Always" Having Positive Experiences*

Satisfaction Measure	STAR Health Proportion of Respondents (N=300)	AHRQ National Medicaid Standards
Getting Needed Care	72.3%	85%
Getting Care Quickly	89.4%	90%
How Well Doctors Communicate	91.4%	93%
Customer Service	LD**	87%
Shared Decision Making	52.9%	N/A
Access to Specialized Services	69.1%	76%
Personal Doctor	84.5%	89%
Coordination of Care	69.7%	76%
Getting Needed Information	89.6%	89%
Getting Prescriptions	88.0%	91%

* The survey was conducted from August to November 2014.
**LD signifies a low denominator. The number of respondents who interacted with the health plan's customer service line was too low for analysis, in this case, fewer than 100 members responding.

Table 38. STAR Health Caregiver Survey CAHPS® Ratings Percent rating at "9" or "10"*

Satisfaction Measure	STAR Health Proportion of Respondents (N=300)	AHRQ National Medicaid Standards
Health Care Rating	61.2%	66%
Personal Doctor Rating	71.3%	73%
Specialist Rating	61.2%	70%
Health Plan Rating	60.2%	67%

*The survey was conducted from August to November 2014.

HHSC also set benchmarks (HHSC performance dashboard indicators) for the agency's performance in several key domains. The relevant results of the STAR health caregiver survey are reported relative to these performance indicator benchmarks in Table 39.

Table 39. Statewide STAR Health Caregiver Survey Results Relative to HHSC Performance Dashboard Indicators*

Performance Dashboard Indicator	STAR Health Total 2014 (N=300)	STAR Health Dashboard Standard (2014)
Good access to urgent care	89.0%	96%
Good access to specialist referral	77.6%	84%
Good access to routine care	89.7%	84%
Good access to behavioral health treatment or counseling	73.8%	79%
Parent/Caregiver rating child's personal doctor "9" or "10"	71.3%	74%
Parent/Caregiver rating child's health plan a "9" or "10"	60.2%	71%
Parent/Caregiver good experiences with doctors' communication	91.4%	94%

*The survey was conducted from August to November 2014.

The surveys about adult services included:

- STAR Adult Member Survey
- STAR+PLUS Adult Member Survey

ICHP used the same protocol for the two telephone-based surveys discussed here as was used with the similar surveys regarding services for children (advanced notification followed by telephone surveys). As with the surveys about children's services, the ICHP surveys about adult services used CAHPS and AHRQ measures.

STAR Adult Member Survey

Purpose

ICHP conducted the member surveys from June 2014 to August 2014 with adults who received services funded through the Medicaid STAR program. STAR serves children in low-income families and adults who meet certain income and eligibility criteria. For adults, the program provides physical and behavioral health services.

The purpose of the STAR Adult Member Survey is to determine members' experiences and level of satisfaction in the STAR program. The survey was conducted with established adult members who had been enrolled in the STAR program for at least six months. Specifically, the survey included questions to address:

- The sociodemographic characteristics and health status of members
- Members' satisfaction with their health care
- Utilization of outpatient and emergency department care
- Access to and timeliness of care, including having an usual source of care
- Preventive care, including check-ups, flu shots, and smoking cessation
- The need for and availability of specialized services
- Members' experiences with their health plan and customer service

Sample and Methods

Participants for the STAR adult member survey were selected from a stratified random sample of beneficiaries ages 18 to 64 years who were enrolled in the same STAR Adult MCO for six continuous months between November 2013 and April 2014. Members having no more than one

30-day break in enrollment in the same MCO during this period were included in the sample. The sample was stratified to include representation from the 45 plan codes (MCO/service areas) and three MRSAs, with a target number of 250 completed surveys per quota. The survey was conducted from June to August 2014. There were 3,627 completed surveys.[25] The response rate was 35 percent, and the cooperation rate was 70 percent.

Major Findings

ICHP presented the findings to HHSC for a number of domains (e.g., how well doctors communicate, customer services, and getting care quickly). The scores in Tables 40 and 41 are presented as composites, which are scores that combine results for closely related survey items (e.g., five questions related to getting care quickly).

Table 40. STAR Adult Member Survey CAHPS® Composites: Percent "Usually" or "Always" Having Positive Experiences*

Satisfaction Measure	Proportion of Respondents (N=3,627)
Getting Needed Care	71.4%
Getting Care Quickly	76.3%
How Well Doctors Communicate	88.1%
Customer Service	87.4%

*The survey was conducted from June to August 2014.

Table 41. STAR Adult Member Survey CAHPS® Ratings: Percent Rating a "9" or "10"*

Satisfaction Measure	Proportion of Respondents (N=3,627)
Health Care Rating	53.5%
Personal Doctor Rating	66.2%
Specialist Rating	65.4%
Health Plan Rating	61.3%

*The survey was conducted from June to August 2014.

[25] This includes results for the long form survey only.

HHSC also set benchmarks (HHSC performance dashboard indicators) for the agency's performance in several key domains, and the relevant results of the STAR adult member survey are also reported relative to these performance indicator benchmarks in Table 42.

Table 42. Statewide STAR Adult Member Survey Results Relative to HHSC Performance Dashboard Indicators*

Performance Dashboard Indicator	STAR Program Survey Results (N=3,627)	STAR Adult Dashboard Standard (2014)
Good access to urgent care	80%	82%
Good access to specialist referral	66%	73%
Good access to routine care	73%	80%
Good access to special therapies	53%	61%
Advising smokers to quit	64%	70%
Good access to behavioral health treatment or counseling	70%	54%
Members rating their health plan "9" or "10"	61%	60%
Good experience with doctor's communication	66%	63%

*The survey was conducted from June to August 2014.

STAR+PLUS Adult Member Survey

The STAR+PLUS program integrates acute and long-term services and supports for clients who are older and/or have disabilities. ICHP conducted the STAR+PLUS Adult Member Surveys from June 2014 to August 2014 with adults who received services funded through the Medicaid STAR+PLUS program.

The intent of this survey was to determine members' level of satisfaction in the STAR+PLUS program. The survey was conducted with Medicaid-only and dual eligible adult members (members also enrolled in Medicare) who were enrolled in the STAR+PLUS program for at least six months.

Specifically, the survey included questions to address:

- The sociodemographic characteristics and health status of members

- Members' satisfaction with their health care
- Access to and timeliness of care, including having an usual source of care
- Preventative care, including check-ups, flu shots, and smoking cessation
- The need for and availability of specialized services
- Members' experiences with their health plan and customer service
- Members' knowledge of and experiences with Service Coordination provided by their health plan

Sample and Methods

Participants for the STAR+PLUS adult member survey were selected from a stratified random sample of beneficiaries age 18 to 64 years who were enrolled in the same STAR+PLUS MCO for six continuous months between November 2013 and April 2014. Members having no more than one 30-day break in enrollment in the same MCO during this period were included in the sample. The sample was stratified to include representation from the 24 plan codes (MCO/service areas) and statewide dual-eligible members in STAR+PLUS. The target number of completes was 250 per quota.

There were 5,843 completed surveys. The response rate was 84 percent, and the cooperation rate was 93 percent.

In addition to AHRQ CAHPS® survey items and items developed by ICHP pertaining to caregiver and member demographic and household characteristics, the STAR+PLUS member survey also included:

- Selected items from the RAND-36 short form survey of self-reported health and functional status
- Items developed by ICHP pertaining to STAR+PLUS service coordination

Major Findings

ICHP presented the findings to HHSC for a number of domains (e.g., how well doctors communicate, customer services, and getting care quickly). The scores in Tables 43 and 44 are presented as composites, which are scores that combine results for closely related survey items (e.g., five questions related to getting care quickly).

Table 43. STAR+PLUS Adult Member Survey CAHPS® Composites: Percent "Usually" or "Always" Having Positive Experiences* (N=5,843)

Satisfaction Measure	STAR+PLUS Medicaid-only Proportion of Respondents	Dual Eligible Proportion of Respondents
Getting Needed Care	65.7%	74.9%
Getting Care Quickly	78.7%	85.4%
How Well Doctors Communicate	86.2%	88.3%
Customer Service	82.3%	LD**

*The survey was conducted from June to August 2014.
** LD signifies a low denominator. The number of respondents who interacted with the health plan's customer service line was too low for analysis, in this case, fewer than 100 members responding.

Table 44. STAR+PLUS Adult Member Survey CAHPS® Ratings: Percent Rating a "9" or "10"* (N=5,843)

Satisfaction Measure	STAR+PLUS Medicaid Only Proportion of Respondents	Dual Eligible Proportion of Respondents
Health Care Rating	52.4%	58.7%
Personal Doctor Rating	66.7%	74.1%
Specialist Rating	70.2%	78.3%
Health Plan Rating	56.5%	62.1%

*The survey was conducted from June to August 2014.

HHSC also set benchmarks (HHSC performance dashboard indicators) for the agency's performance in several key domains, and the relevant results of the STAR+PLUS adult member survey are also reported relative to these performance indicator benchmarks in Table 45.

Table 45. Statewide STAR Adult Member Survey Results Relative to HHSC Performance Dashboard Indicators*
(N=5,843)

Performance Dashboard Indicator	STAR+PLUS Medicaid-only Proportion of Respondents	Dual Eligible Proportion of Respondents	STAR+PLUS Dashboard Standard (2014)
Good access to urgent care	79.1%	89.5%	82%
Good access to specialist referral	66.6%	74.4%	73%
Good access to routine care	78.3%	81.2%	80%
Good access to special therapies	45.7%	78.5%	66%
Good access to service coordination	58.1%	LD**	68%
Advising smokers to quit	67.8%	75.4%	70%
Good access to behavioral health treatment or counseling	60.6%	80.0%	67%
Members rating their health plan "9" or "10"	56.5%	62.1%	56%
Members rating their personal doctor a "9" or "10"	66.7%	74.1%	64%
Good experience with doctor's communication	86.2%	88.3%	89%

*The survey was conducted from June to August 2014.

**LD signifies a low denominator. The number of respondents who interacted with the health plan's customer service line was too low for analysis, in this case, fewer than 30 members in the denominator.

III. Self-service Portal for Benefits Enrollment

YourTexasBenefits.Com Survey

Purpose

Historically, Texans who have wanted to apply for public benefits such as Medicaid, CHIP, or SNAP have done so by visiting eligibility offices and working with clerks and other HHSC staff. However, in recent years, HHSC created a website, YourTexasBenefits.com, which gives customers the opportunity to manage their benefits online rather than going in to an eligibility

office. Customers use the website to apply for and renew benefits, view their case statuses, report changes to their cases, and upload documents needed for their applications. Since 2012, HHSC increasingly promoted the website, and customers who came into offices in person may have been asked to use the website to perform tasks that they could complete themselves. Most eligibility offices have computers that clients may use to access the website.

After customers use the YourTexasBenefits.com website and log out, all users are prompted to complete a brief online survey. The purpose of this ongoing survey is to assess customers' satisfaction and experiences with the website.

The questionnaire collects data about:

- Computer access and frequency of use
- Reasons for using YourTexasBenefits.com
- Length of time it took to complete certain actions on YourTexasBenefits.com
- Expected future use of YourTexasBenefits.com
- Perception of ease of use and timeliness

Sample and Methods

The YourTexasBenefits.com survey went live in August 2012. It is available in both English and Spanish and includes 27 questions. The number of questions visitors may be prompted to answer varies depending on their reasons for using the website.

In 2015, there were 20,636 completed surveys – an average of 1,720 responses per month. The number of people who received the survey request is not known with precision, so a response rate cannot be calculated.

Summary of Major Findings

Most respondents were satisfied with their experiences using the YourTexasBenefits.com website in 2015.

Positive Findings

Positive findings of the YourTexasBenefits.com survey include:

- The majority of respondents indicated that it was easy or very easy to find what they were looking for (70 percent), apply for benefits (73 percent), renew benefits (73 percent), or report a change (70 percent).
- 75 percent of respondents said they would recommend the website to a friend.
- The majority of respondents reported that the time it took to apply for benefits (62 percent), renew benefits (65 percent), and report a change (63 percent) was just right.

- 82 percent of respondents reported that they expected to use YourTexasBenefits.com again in the future.

Opportunities for Improvement

- Of those who applied online, about five of ten (46 percent) found the questions on the application confusing or hard to answer. Customers reported that the questions that were more confusing or hard to answer on the applications were:
  - Things owned/property/cars/valuables - 38 percent
  - People on their case or people living in their home - 44 percent
  - Money that people in their home make or get - 41 percent
  - Other - 41 percent
- Of those who renewed their benefits online, four out of ten found the questions on renewal forms confusing or hard to answer. Customers generally reported the same categories being confusing as those reported for new applications.

CONCLUSION

This HHS system-wide 2016 Report on Customer Service describes the results of 92,135 individual survey responses from 34 surveys conducted by the five HHS agencies. Not all customer satisfaction surveys conducted by HHS agencies are included here; some that had research designs that did not hold up to scientific rigor and those with very low response rates are not included. Individuals who were surveyed were primarily direct consumers of services and enrollees in health plans; other surveys solicited feedback from entities licensed or regulated by HHS, service providers contracted with HHS, and community stakeholders.

- Nineteen projects surveyed customers of HHS services, including families of children with special needs, adults with disabilities, children and adults who received mental health services, elderly individuals residing in care facilities, young adults leaving foster care, families involved with the child protective services system, and customers of eligibility offices. The largest of these surveys, the YourTexasBenefits.com survey, collected responses of over two thousand customers *per month* on average. Overall, most respondents provided positive feedback regarding the services and supports they received through HHS programs.
- Enrollees in STAR, STAR Health, STAR+PLUS, and CHIP health plans were surveyed through six different surveys. Respondents included families or caregivers of enrolled children as well as enrolled adults. Across all surveys, many quality components were rated positively, meeting or exceeding dashboard benchmarks. Components that did not meet benchmarks or other standards were addressed as areas for improvement in each survey report.
- Four surveys were conducted to receive feedback from entities regulated or licensed by the state - one from contractors providing services for the state, two for healthcare providers registered to provide vaccines, and one for facilities participating in the laboratory courier program. These surveys all showed satisfaction among customers of the various programs.
- One survey was conducted to obtain feedback from community stakeholders. Generally positive feedback was provided by community stakeholders regarding Adult Protective Services.

Overall, the HHS system of agencies has succeeded in obtaining feedback from a diverse group of customers. Most customers of services provided positive feedback regarding the services and supports they received through HHS programs. Feedback which identified opportunities for improvement will inform how services are provided in the future. These results support the HHS system vision of providing high quality, cost-effective services resulting in improved health, safety, and greater independence for Texans.

APPENDIX A: CUSTOMER INVENTORY FOR THE DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
A.1.1.: The Intake, Access and Eligibility to Services and Supports strategy provides functional eligibility determination, development of individual service plans that are based on consumer needs and preferences, assistance in obtaining information, and authorizing appropriate services and supports through effective and efficient management of DADS staff, and contracts with the Area Agencies on Aging (AAAs) and Local Authorities (LAs).	**Direct customer groups include:** • Individuals who are older who meet specific eligibility requirements; • Individuals with physical, intellectual and/or developmental disabilities who meet specific eligibility requirements; and • Family members and caregivers of individuals who are older and those with disabilities who meet specific eligibility criteria.
A.1.2.: The DADS Guardianship strategy provides guardianship services, either directly or through contracts with local guardianship programs, to individuals referred to the program by DFPS after a validated incident of abuse, neglect, or exploitation.	**Direct customer groups include:** • Individuals with diminished capacity who are older and who meet specific eligibility requirements; • Individuals with diminished capacity who have a disability and who meet specific eligibility requirements; and • Individuals with diminished capacity who are aging out of CPS conservatorship.
A.2.1.: The Primary Home Care (PHC) strategy provides non-skilled, personal care services for individuals whose chronic health problems impair their ability to perform activities of daily living (ADLs). Personal attendants assist individuals in performing ADLs, such as arranging or accompanying individuals on trips to receive medical treatment, bathing, dressing, grooming, preparing meals, housekeeping and shopping. On average, individuals are authorized to receive approximately 16.6 hours of assistance per week.	**Direct customer groups include:** • Individuals 21 years of age and older; • Individuals who meet eligibility requirements including Medicaid eligibility; • Individuals who have a practitioner's statement of medical need; and • Individuals who meet functional assessment criteria.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
A.2.2.: The Community Attendant Services (CAS) strategy provides non-skilled personal care services for individuals whose chronic health problems impair their ability to perform ADLs and whose income makes them ineligible for PHC. Personal attendants provide services to assist individuals in performing ADLs, such as arranging or accompanying the individual on trips to receive medical treatment, bathing, dressing, grooming, preparing meals, housekeeping and shopping. On average, individuals are authorized to receive approximately 16.4 hours of assistance per week. (Note: The term Frail Elderly is still used in federal language to refer to the law where the Federal legal authority can be located as part of the Social Security Act).	**Direct customer groups include:** Individuals of any age who meet specific eligibility requirements including income and resources, who have a practitioner's statement of medical need and meet functional assessment criteria.
A.2.3.: The Day Activity and Health Services (DAHS) strategy provides licensed adult day care facility daytime services five days a week (Monday-Friday). Services are designed to address the physical, mental, medical and social needs of individuals, and must be provided or supervised by a licensed nurse. Services include nursing and personal care, noontime meal, snacks, transportation, and social, educational, and recreational activities. Individuals receive services based on half-day (three to six hours) units of service; an individual may receive a maximum of 10 units of service a week, depending on the physician's orders and related requirements.	**Direct customer groups include:** • Title XIX: Individuals age 18 or older who receive Medicaid and meet eligibility requirements, which include having a functional disability related to a medical condition, a need for a personal care task, and a medical diagnosis and physician's orders requiring care or supervision by a licensed nurse. • Title XX: Individuals age 18 or older who meet specific eligibility requirements including income and resources and who have a functional disability related to a medical condition, a need for a personal care task, and a medical diagnosis and physician's orders requiring care or supervision by a licensed nurse.
A.2.4: The Habilitation Services strategy provides entitlement attendant care and habilitation services for persons with IDD who are eligible for Medicaid with incomes at or below 150 percent of the federal poverty level.	**Direct customer groups include:** Individuals of all ages who meet specific eligibility requirements, including diagnosis of an intellectual disability or related condition and mild to extreme deficits in adaptive behavior.
A.3.1.: The Home and Community-Based Services	**Direct customer groups include:**

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
strategy provides services and supports for individuals with intellectual or developmental disabilities as an alternative to an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID). Individuals may live in their own or family home, in a foster/companion care setting or in a residence with no more than four individuals who receive similar services. Services include case management, and as appropriate, residential assistance, supported employment, day habilitation, respite, dental treatment, adaptive aids, minor home modifications, and/or specialized therapies such as social work, behavioral support, occupational therapy, physical therapy, audiology, speech/language pathology, dietary services and licensed nursing services.	Individuals of any age who have a determination/diagnosis of intellectual disability or related condition, who meet Medicaid eligibility, resource and level of care criteria, and who choose Home and Community-based Services (HCS) services instead of the ICF/IID program.
A.3.2.: The Community Living Assistance and Support Services strategy provides services and supports for individuals with related conditions as an alternative to residing in an ICF/IID. Individuals may live in their own or family home. Services include adaptive aids and medical supplies, case management, consumer directed services, habilitation, minor home modifications, nursing services, occupational and physical therapy, behavioral support services, respite, specialized therapies, speech pathology, pre-vocational services, supported employment, support family services and transition assistance services.	**Direct customer groups include:** Individuals of any age with a diagnosis of developmental disability other than intellectual disability who meet specific eligibility requirements including Medicaid eligibility and functional need, and who choose waiver services instead of institutional services.
A.3.3.: The Deaf, Blind and Multiple Disabilities strategy provides services and supports for individuals with deaf blindness and one or more other disabilities as an alternative to residing in an ICF/IID. Individuals may reside in their own or family home or in small group homes. Services include adaptive aids and medical supplies, dental services, assisted living, behavioral support services, case management, chore services, minor home modifications, residential habilitation, day habilitation, intervener, nursing services, occupational therapy, physical therapy, orientation and mobility, respite, speech, hearing and language therapy, supported employment, employment assistance, dietary services, financial management services for the consumer directed services option and transition assistance services.	**Direct customer groups include:** Individuals of any age who are deaf, blind, and have a third disability, who meet specific eligibility requirements including Medicaid eligibility and functional need and who choose waiver services instead of institutional services.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
A.3.4.: The Medically Dependent Children Program strategy provides a variety of services and supports for families caring for children who are medically dependent as an alternative to residing in a nursing facility. Specific services include adaptive aids, adjunct support services, minor home modifications, respite, financial management services and transition assistance services.	**Direct customer groups include:** Individuals younger than age 21 who meet specific eligibility requirements including income, resource, and medical necessity criteria, and who choose waiver services instead of nursing facility services.
A.3.5. (New Number): The Texas Home Living Waiver strategy provides essential services and supports for individuals with intellectual or developmental disabilities as an alternative to residing in an ICF/IID. Individuals must live in their own or family homes. Service components are comprised of the Community Living Supports (CLS) category and the Technical and Professional Supports Services category. The CLS category includes community support, day habilitation, employment assistance, supported employment and respite services. The Technical and Professional Supports Services category includes skilled nursing, behavioral support, adaptive aids, minor home modifications, dental treatment and specialized therapies. Coordination of services is provided by the local intellectual disability authority service coordinator.	**Direct customer groups include:** Individuals of any age who have a determination/diagnosis of intellectual disability or related condition, who meet specific eligibility requirements including Medicaid eligibility, resource and level of care criteria, and who choose waiver services over ICF/IID.
A.4.1.: The Non-Medicaid Services strategy provides services and supports in community settings to enable individuals who are aging and those with disabilities to remain in the community, maintain their independence and avoid institutionalization. Services included in this strategy are Adult Foster Care, Consumer Managed Personal Attendant Services, Day Activity and Health Services, Emergency Response Services, Family Care, Home-Delivered Meals, Residential Services and Special Services for Persons with Disabilities.	**Direct customer groups include:** • Non-Medicaid community (Title XX and general revenue funded) services are provided to individuals 18 years of age or older who meet specific eligibility requirements including income, resource and functional assessment criteria. • Older Americans Act (OAA) services are provided to individuals age 60 or older, their family caregivers and other caregivers caring for an eligible person.
A.4.2.: The Intellectual Disability Community Services strategy implements the Health and Safety Code, §533.035, in which the LA provides individuals access to publicly funded services for individuals with	**Direct customer groups include:** Individuals with a determination/diagnosis of intellectual disability who reside in the

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
intellectual and developmental disabilities. The strategy provides for the determination of eligibility and services and supports for individuals in the intellectual and developmental disabilities priority population who reside in the community, other than services provided through ICF/IID and Medicaid waiver programs. These services include service coordination, community support to assist individuals to participate in age-appropriate activities and services; employment services to assist individuals in securing and maintaining employment; day training services to help individuals develop and refine skills needed to live and work in the community; various therapies that are provided by licensed or certified professionals and respite services for the individual's primary caregiver.	community.
A.4.3.: This strategy implements the **Texas Promoting Independence Plan,** developed in response to the U.S. Supreme Court ruling in Olmstead v. L.C. and two Executive Orders, GWB99-2 and RP13. The Promoting Independence Plan includes community outreach and awareness and relocation services. Community outreach and awareness is a program of public information developed to target groups that are most likely to be involved in decisions regarding long-term services and supports. Relocation services involve assessment and case management to assist individuals in nursing facilities who choose to relocate to community-based services and supports. It includes funding for Transition to Living in the Community services to cover establishing and moving to a community residence.	**Direct customer groups include:** Nursing Facility residents who have indicated a desire to relocate back into a community setting through either a personal request or through the Minimum Data Set 3.0 Section Q process. Contractors who provide relocation services and who provide Transition Assistance Services and Transition to Life in the Community.
A.4.4.: The In-Home and Family Support) strategy is a grant program that provides financial assistance to eligible persons and families for the purpose of purchasing items that meet a need that exists solely because of the person's intellectual disability or co-occurring physical disability. The program directly supports the person to live in his or her natural home, integrates the person into the community, or promotes the person's self-sufficiency. Funds may be used for services such as respite care, specialized therapies,	**Direct customer groups include:** Individuals with physical disabilities who need to purchase items above and beyond the scope of usual needs necessitated by the person's disability and directly supporting the individual’s ability to live in his/her own home.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
home care, counseling and training, such as in-home parent training, special equipment, such as therapy equipment assistive technology, home modifications, transportation and other items that meet the program's criteria. There is a limit of $1,200 per year, with the amount granted dependent upon on the individual's needs.	
A.5.1.: The Program for All-Inclusive Care for the Elderly (PACE) strategy is an integrated managed care system for individuals who are aged or disabled. PACE provides community-based services in El Paso, Lubbock and Amarillo for individuals age 55 or older who qualify for nursing facility admission. PACE uses a comprehensive care approach, providing an array of services for a capitated monthly fee. PACE provides all health-related services for an individual, including in-patient and out-patient medical care, and specialty services, including dentistry, podiatry, social services, in-home care, meals, transportation, day activities and housing assistance.	**Direct customer groups include:** Individuals age 55 or older who qualify for nursing facility services, and receive Medicare and/or Medicaid.
A.6.1: The Nursing Facility Payments strategy provides payments to promote quality of care for individuals with medical problems that require nursing facility or hospice care. The types of payments include Nursing Facility Care, Medicaid Swing Bed Program, Augmented Communication Device Systems, Customized Power Wheelchairs, Emergency Dental Services, Specialized and Rehabilitative Services. The Nursing Facility Payments provides institutional nursing care for individuals whose medical condition requires the skills of a licensed nurse on a regular basis. The nursing facility must provide for the medical, nursing, and psychosocial needs of each individual, to include room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid Vendor Drug program or Medicare Part D), medical supplies and equipment, personal needs items and rehabilitative therapies.	**Direct customer groups include:** Individuals with medical needs meeting medical necessity requirements and are eligible for Medicaid. The individuals must reside in a nursing facility for 30 consecutive days.
A.6.2.: The Medicare Skilled Nursing Facility	**Direct customer groups include:**

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
(SNF) strategy covers the payment of Medicare SNF co-insurance for Medicaid recipients in Medicare (XVIII) facilities. Medicaid also pays the co-payment for Medicaid Qualified Medicare Beneficiary (QMB) recipients, and for "Pure" (i.e., Medicare-only) QMB recipients. For recipients in dually certified facilities (certified for both Medicaid and Medicare), Medicaid pays the coinsurance less the applied income amount for both Medicaid only and Medicaid QMB recipients. For "Pure" QMB recipients, the entire coinsurance amount is paid. The amount of Medicare co-insurance per day is set by the federal government at one-eighth of the hospital deductible.	Individuals who receive Medicaid and reside in Medicare (XVIII) skilled nursing facilities, Medicaid/ QMB recipients and Medicare only QMB recipients.
A.6.3.: The Medicaid Hospice strategy provides services to Medicaid individuals who have a physician's prognosis of six months or less to live and who no longer desire curative treatments. Individuals under the age of 21 may continue to receive curative treatments while receiving hospice services. Available services include physician and nursing care; medical social services; counseling; home health aide; personal care, homemaker and household services; physical, occupational, or speech language pathology services; bereavement counseling; medical appliances and supplies; drugs and biologicals; volunteer services; general inpatient care (short-term); and respite care. Service settings can be in the home, community settings, or in long-term-care facilities. Medicaid rates for community-based Hospice are based on Medicare rates set by the Center for Medicare and Medicaid Services (CMS). For individuals residing in a nursing facility or an ICF/IID and receiving hospice services, the facility also receives a payment of 95% of the established nursing facility rate for that individual.	**Direct customer groups include:** Individuals eligible for Medicaid who are terminally ill and no longer desire curative treatment and who have a physician's prognosis of six months or less to live. Individuals under the age of 21 may continue to receive curative treatments while receiving hospice services.
A.6.4.: The Promote Independence by Providing Community-based Services strategy supports "the Money Follows the Person" provisions which allow a Medicaid-eligible nursing facility resident to relocate back into the community and to receive long-term services and supports. Dollars from this strategy specifically fund the community-based services which support the individual while he/she resides in the	**Direct customer groups include:** Nursing Facility (NF) residents, who are Medicaid eligible, who have indicated their desire to relocate back into a community setting, who have been in the NF for 30 days and who meet community based waiver functional eligibility

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
community setting. Services may include 1915(c) waiver or other community services and do not impact funding supported by the other community-based services. Assistance is available from DADS contracted relocation specialists who provide outreach, facilitation and coordination with nursing facility relocation for individuals with complex needs. In addition, the AAA provide information about community options such as housing, health care, transportation, daily living and social activities that can help individuals and their families make a decision from the planning phase to actual relocation in the community.	requirements.
A.7.1.: The ICFs/IID strategy funds residential facilities serving four or more individuals with intellectual and developmental disabilities. Section 1905(d) of the Social Security Act created this optional Medicaid benefit to certify and fund these facilities. Each private or public facility must comply with federal and state standards, laws and regulations. These facilities provide active treatment, including diagnosis, treatment, rehabilitation, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at their greatest ability.	**Direct customer groups include:** Individuals with intellectual and/or developmental disabilities who would benefit or require 24-hour supervised living arrangements and qualify for Medicaid.
A.8.1.: The State Supported Living Centers (SSLC) strategy provides direct services and support for individuals admitted to the twelve state-supported living centers and one state center providing intellectual and developmental disability residential services. SSLCs are located in Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio. The Rio Grande State Center is in Harlingen and is operated by DSHS through a contract with DADS. Each center is certified as a Medicaid-funded ICF/IID. Approximately 60% of the operating funds are received from the federal government and 40% from State General Revenue or third-party sources.	**Direct customer groups include:** Individuals who have a determination/diagnosis of intellectual disability who are medically fragile or who have behavioral problems.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
The SSLCs and the Rio Grande State Center provide 24-hour residential services, comprehensive behavioral treatment and health care services including physician, nursing and dental services. Other services include skills training; occupational, physical and speech therapies; vocational programs, employment; and services to maintain connections between residents and their families/natural support systems.	
A.9.1: The Capital Repairs and Renovations strategy funds the construction and renovation of facilities at the SSLCs and State-owned bond homes for individuals with intellectual and developmental disabilities. The vast majority of projects currently funded and underway are to bring existing facilities into compliance with the requirements in the Life Safety Code and/or other critical repairs and renovations, including fire sprinkler systems, fire alarm systems, emergency generators, fire/smoke walls, roofing, air conditioning, heating, electrical, plumbing, etc. The large number of buildings on site at the SSLCs and the age of many of these buildings necessitates ongoing capital investments to ensure that the buildings are functional, safe, and in compliance with all pertinent standards. Compliance with such standards is mandatory to avoid the loss of federal funding for the state facilities.	**Direct customer groups include:** Individuals who have a determination/diagnosis of intellectual disability who are medically fragile or who have behavioral problems.
B.1.1.: The Facility and Community-based Regulation strategy covers the licensing and regulation of all long-term care facilities/agencies that meet the definition of nursing homes, assisted living facilities, adult day-care facilities, privately owned ICFs/IID and Home and Community Support Services Agencies (HCSSAs). Licensed facilities/agencies wishing to participate in Medicare and/or Medicaid programs must be certified and maintain compliance with certification regulations according to Titles XVIII and/or XIX of the Social Security Act. Government-operated ICFs/IID and skilled nursing units within an acute care hospital are also required to be certified in order to participate in Medicare and/or	**Direct customer groups include:** • Providers of long-term care services that meet the definitions of nursing facility, assisted living facility, day activity and health services facility, private intermediate care facility for persons with an intellectual disability, prescribed pediatric extended care center or home and community support services agency; • Persons receiving services in facilities or from agencies regulated under this strategy; • Persons eligible to receive services

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
Medicaid. In addition to licensing these long-term care facilities and agencies, DADS responsibilities for these regulated programs include investigating complaints and self-reported incidents; monitoring facilities for compliance with state and/or federal regulations; certification review of HCS waiver contracts and Texas Home Living program (TxHmL) waiver contracts; investigating complaints related to HCS and TxHmL services; and receiving and following up on DFPS findings related to abuse, neglect, or exploitation investigations of persons who receive HCS or TxHmL services.	under TxHmL and HCS waiver contracts; and • Family and community members of persons receiving services in facilities or agencies regulated under this strategy who may obtain assurance that regulated facilities and agencies meet the minimum standard of care required by statute and regulation.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
B.1.2.: The Credentialing/Certification strategy covers DADS licensing, certification, permitting and monitoring of individuals for the purpose of employability in facilities and agencies regulated by DADS through four credentialing programs. **Nursing Facility Administrator Licensing and Enforcement** responsibilities include licensing and continuing education activities; investigating complaints or referrals; coordinating sanction recommendations and other licensure activities; imposing and monitoring sanctions and due process considerations; and developing educational, training, and testing curricula. **Nurse Aide Registry (NAR) and Nurse Aide Training and Competency Evaluation Program (NATCEP)** responsibilities include nurse aide certification and sanction activities; approving, renewing or withdrawing approval of NATCEPs; and due process considerations and determination of nurse aide employability in DADS regulated facilities via the NAR. **Employee Misconduct Registry (EMR)** responsibilities include due process considerations and determination of unlicensed staff employability in DADS regulated facilities/agencies via the EMR. Medication Aide Program responsibilities include medication aide permit issuance and renewal; imposing and monitoring sanctions; due process considerations; approving and monitoring medication aide training programs in educational institutions; and coordinating/administering examinations.	**Direct customer groups include:** • Persons employed or seeking employment as nursing facility administrators, nurse aides and medication aides benefit from training and from assurance that people working in the field meet minimum standards; • Providers of long-term care services that meet the definitions of nursing facility, assisted living facility, day activity and health services facility, private intermediate care facility for persons with an intellectual disability, prescribed pediatric extended care center or home and community support services agency benefit from training programs for employees, from monitoring of certification of employees and from access to misconduct registry for unlicensed or unregistered employees; • Employers of nurse aides and medication aides, including long-term care service and related providers who benefit from public access to information in the NAR and EMR to enhance pre-employment verification of employability; • Persons receiving services in facilities or from agencies regulated by DADS benefit from having a more highly qualified workforce as caregivers and administrators; and • Family and community members of persons receiving services in facilities or agencies regulated under this strategy who may obtain assurance that caregivers meet minimum standards through licensing and credentialing.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
B.1.3.: The Long-Term Care Quality Outreach strategy performs a variety of functions designed to enhance the quality of services and supports. Quality monitors, who are nurses, pharmacists, and dietitians, provide technical assistance to long-term facility staff. The quality monitors perform structured assessments to promote best practice in service delivery. In addition, quality monitors provide in-service education programs. Quality Monitoring Team visits are also provided to facilities and may include more than one discipline during the same visit. The technical assistance visits focus on specific, statewide quality improvement priorities for which evidence-based best practice can be identified from published clinical research. The program works to improve clinical outcomes for individuals, such as pain assessment, pain management, infection control, appropriate use of psychoactive medications, risk management for falls, improving nutritional practices, use of artificial nutrition and hydration, and advance care planning. The purpose of the program is to increase positive outcomes and to improve the quality of services for individuals served in these settings. A related website, http://www.TexasQualityMatters.org, supports the program by providing online access to best-practice information and links to related research.	**Direct customer groups include:** Staff in nursing homes, SSLCs, ICFs, Assisted Living Facilities (ALFs) and the people who live in these settings. Quality Monitoring Program (QMP) staff provide in-services which are attended by the people who live there, as well as their family members.

APPENDIX B: CUSTOMER INVENTORY FOR THE DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES (DARS)

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
A.1.1.: Early Childhood Intervention (ECI) Services. Administer a statewide comprehensive system of services to ensure that eligible infants, toddlers and their families have access to the resources and support they need to reach their service plan goals.	**Children with Disabilities & Their Families:** DARS serves families with children birth to 36 months with developmental disabilities or delays and must provide early childhood intervention services to all eligible children.
A.1.2.: ECI Respite Services. Ensure that resources are identified and coordinated to provide respite service to help preserve the family unit and prevent costly out-of-home placements.	**Children with Disabilities & Their Families:** DARS provides respite services to families served by the ECI program.
A.1.3.: Ensure Quality ECI Services. Ensure the quality of early intervention services by offering training and technical assistance, establishing service and personnel standards, and evaluating consumer satisfaction and program performance.	**Children with Disabilities & Their Families:** DARS carries out activities required under the federal Individuals with Disabilities Education Act (IDEA), including ensuring the availability of qualified personnel to serve all eligible children, involving families and stakeholders in policy development, evaluating services, providing impartial opportunities for resolution of disputes, and guaranteeing the rights of the children and families are protected.
A.2.1.: Children's Blindness Services. Provide information and training for blind and visually impaired children and their families so these children have the skills and confidence to live as independently as possible.	**Blind or Visually Impaired Consumers & Their Families:** DARS provides services necessary to assist blind children to achieve self-sufficiency and a fuller richer life.
A.3.1.: Autism Program. To provide services to Texas children ages 3-15 diagnosed with autism spectrum disorder.	**Children with Autism & Their Families:** DARS provides treatment services to children with a diagnosis of autism.
B.1.1.: Independent Living Services and Council – Blind. Provide quality, statewide independent living services that focus on acquiring skills and confidence to live as independently as possible in the community for eligible persons who are blind or visually impaired. Work with the State Independent Living	**Blind or Visually Impaired Consumers:** DARS is responsible for providing services that assist Texans with visual disabilities to live as independently as possible.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
Council to develop the State Plan for Independent Living.	
B.1.2.: Blindness Education, Screening and Treatment (BEST) Program. Provide screening, education, and urgently needed eye-medical treatment to prevent blindness.	**Texans:** DARS provides public education about blindness, screenings and eye exams to identify conditions that may cause blindness and treatment procedures necessary to prevent blindness.
B.1.3.: Vocational Rehabilitation - Blind. Rehabilitate and place persons who are blind or visually impaired in competitive employment or other appropriate settings, consistent with informed choice and abilities.	**Blind or Visually Impaired Consumers:** DARS provides services designed to assess, plan, develop and use vocational rehabilitation services for individuals who are blind consistent with their strengths, resources, priorities, concerns and abilities so that they may prepare for and engage in gainful employment. **Texans/Taxpayers:** DARS promotes employment, often reducing dependence on state-funded programs and increasing tax revenue for the state. **Employers:** DARS work with people with disabilities and employers to identify appropriate job placements for these individuals.
B.1.4.: Business Enterprises of Texas (BET). Provide employment opportunities in the food service industry for persons who are blind or visually impaired.	**Blind or Visually Impaired Consumers:** DARS provides training and employment opportunities in the food service industry for Texans who are blind or visually impaired.
B.1.5.: BET Trust Fund. Administer trust funds for retirement and benefits program for individuals licensed to operate vending machines under BET (estimated and nontransferable).	**Blind or Visually Impaired Consumers in the BET program:** DARS has established and maintains a retirement and benefit plan for blind or visually impaired individuals who are licensed managers in the BET program.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
B.2.1.: Contract Services - Deaf. Develop and implement a statewide program to ensure continuity of services to persons who are deaf or hard of hearing. Ensure more effective coordination and cooperation among public and nonprofit organizations providing social and educational services to individuals who are deaf or hard of hearing.	**Deaf or Hard of Hearing Consumers:** DARS, through a network of local service providers at strategic locations throughout the state, provides communication access services including interpreter services and computer assisted real-time transcription services, information and referral, hard of hearing services, and resource specialists' services.
B.2.2.: Education, Training, Certification - Deaf. Facilitate communication access activities through training and educational programs to enable individuals who are deaf or hard of hearing to attain equal opportunities to participate in society to their potential and reduce their isolation regardless of location, socioeconomic status, or degree of disability. To test interpreters for the deaf and hard of hearing to determine skill level and certify accordingly, and to regulate interpreters to ensure adherence to interpreter ethics.	**Deaf or Hard of Hearing Consumers;** DARS provides services through a statewide program of advocacy and education on topics such as ADA, hard of hearing issues and interpreter training. **Higher Education Institutions and Students:** DARS assists institutions of higher education in initiating training programs for interpreters. **Current and Potential Interpreters:** DARS provides skills building and training opportunities for interpreters and coordinates training sponsored by other entities. **Current and Potential Interpreters:** DARS administers a system to determine the varying levels of proficiency of interpreters and maintains a certification program for interpreters. **Texans who are Deaf:** DARS ensures that interpreters are able to adequately assist in the communication facilitation process for people who are deaf or hard of hearing.
B.2.3.: Telephone Access Assistance. Ensure equal access to the telephone system for persons with a disability (estimated and nontransferable).	**Consumers with Disabilities:** DARS provides vouchers for the purchase of specialized telecommunications equipment for access to the telephone network for eligible persons with disabilities.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
B.3.1.: Vocational Rehabilitation - General. Rehabilitate and place people with general disabilities in competitive employment or other appropriate settings, consistent with informed consumer choice and abilities.	**Consumers with Disabilities Other than Blindness:** DARS provides services leading to employment consistent with consumer choice and abilities for eligible persons with disabilities. **Texans/Taxpayers:** The VR program promotes employment, often reducing dependence on state-funded programs and increasing tax revenue for the state. **Employers:** DARS works with people with disabilities and employers to identify appropriate job placements for these individuals.
B.3.2.: Centers for Independent Living. Work with centers for independent living to establish the centers as financially and programmatically sustainable and accountable for achieving independent living outcomes with their clients.	**Consumers with Disabilities:** Centers for Independent Living offer services to eligible consumers with significant disabilities who are interested and can benefit, regardless of vocational potential. Centers provide, at the minimum, the following core services: advocacy, peer counseling, independent living skills training, and information and referral.
B.3.3.: Independent Living (IL) Services and Council - General. Provide quality, statewide consumer-directed independent living services that focus on acquiring skills and confidence to live as independently as possible in the community for eligible people with significant disabilities. Work with the State Independent Living Council to develop the State Plan for Independent Living.	**Consumers with Disabilities Other than Blindness:** DARS provides people with significant disabilities, who are not receiving vocational rehabilitation services, with services that will substantially improve their ability to function, continue functioning, or move toward functioning independently in the home, family, or community.
B.3.4.: Comprehensive Rehabilitation (CRS). Provide consumer-driven and counselor-supported Comprehensive Rehabilitation Services for people with traumatic brain injuries or spinal cord injuries.	**Consumers with Traumatic Brain or Spinal Cord Injuries:** DARS provides adults who have suffered a traumatic brain or spinal cord injury with comprehensive inpatient or outpatient rehabilitation and/or acute brain injury services.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
C.1.1.: Disability Determination Services (DDS). Determine eligibility for federal Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits.	**Texans Applying for SSI or SSDI:** DARS determines whether persons who apply for Social Security Administration (SSA) disability benefits meet the requirements for "disability" in accordance with federal law and regulations. **Federal government**: DARS assists SSA in making disability determination decisions for this federal program in a quick, accurate and cost-effective manner.
D.1.1.: Central Program Support.	**DARS Employees:** DARS provides central support services for DARS employees.
D.1.2.: Regional Program Support.	**DARS Employees:** DARS provides central support services for DARS employees.
D.1.3.: Other Program Support.	**DARS Employees:** DARS provides central support services for DARS employees.
D.1.4.: IT Program Support.	**DARS Employees:** DARS provides central support services for DARS employees.

APPENDIX C: CUSTOMER INVENTORY FOR THE DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS)

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
A.1.1: Statewide Intake Services. Provide a comprehensive system with automation support for receiving reports of persons suspected to be at risk of abuse/neglect/exploitation and assign for investigation those reports that meet Texas Family Code and Human Resources Code definitions.	**Children and Adults At Risk of Abuse and Neglect:** Statewide Intake provides central reporting and investigation assignments so that all children at risk of abuse and neglect and all elderly and adults with disabilities who have been abused, neglected, and exploited can be protected. **Citizens of Texas:** DFPS provides confidential access to services for all citizens of Texas. **External Partners:** In providing access to DFPS services through the Statewide Intake function, DFPS interacts with law enforcement agencies, the medical sector, schools, and the general reporting public.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
B.1.1: CPS Direct Delivery Staff. Provide caseworkers and related staff to conduct investigations and deliver family-based safety services, out-of-home care, and permanency planning for children who are at risk of abuse/neglect and their families. **B.1.2: CPS Program Support.** Provide staff, training, automation, and special projects to support a comprehensive and consistent system for the delivery of child protective services.	**Children and Families:** DFPS protects children by investigating reports of abuse and neglect, working with children and families in their own homes to alleviate the effects of abuse/neglect, and providing services to prevent further abuse/neglect, and if necessary, placing children in substitute care until they can be safely returned home, to relatives, or until they are adopted. **External Partners**: Conducting investigations and providing casework for children in their own homes and children who have been removed from their homes involves many external partners, such as law enforcement agencies, the medical sector, schools, Child Welfare Boards, the judiciary, faith-based organizations, Child Advocacy Centers, children's advocate groups, domestic violence service providers, other HHSC system agencies, and state and national child welfare associations.
B.1.3: TWC Contracted Day Care. Provide purchased day care services for foster children where both or the one foster parent works full-time and provide purchased day care services for children living at home to control and reduce the risk of abuse/neglect and to provide stability while a family is working on changes to reduce the risk.	**Children and Families:** DFPS protects children by purchasing day care to keep a child safe in their home or to assist working foster parents. **Other Agencies:** DFPS purchases day care under a contract with the Texas Workforce Commission. **Local Governments:** Through the contract with the Texas Workforce Commission, DFPS has access to the network of child care providers managed by local workforce boards.
B.1.4: Adoption Purchased Services. Provide purchased adoption services with private child-placing agencies to facilitate the success of service plans for children who are legally free for adoption, including recruitment, screening, home study, placement, and support services.	**Children and Families:** DFPS increases permanency placement options for children awaiting adoption by contracting for adoption services, and helps ensure success of adoptions by providing post-adoption services.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
B.1.5: Post-Adoption Purchased Services. Provide purchased post-adoption services for families who adopt children in the conservatorship of DFPS, including casework, support groups, parent training, therapeutic counseling, respite care, and residential therapeutic care.	**Contracted Service Providers:** DFPS contracts with private child-placing agencies to recruit, train and verify adoptive homes, secure adoptive placements, provide post-placement supervision, and facilitate the consummation of the adoptions. DFPS also purchases post-adoption services from various service providers.
B.1.6: Preparation for Adult Living Purchased Services. Provide purchased adult living services to help and support youth preparing for departure from DFPS substitute care, including life skills training, money management, education/training vouchers, room and board assistance, and case management.	**Youth in Substitute Care:** DFPS provides services to prepare youth in substitute care for adult life. Services are also available for youth who have aged out of the substitute care system to ensure a successful transition to adulthood. **Contracted Service Providers:** DFPS purchases these youth services from various service providers.
B.1.7: Substance Abuse Purchased Services. Provide purchased residential chemical dependency treatment services for adolescents who are in the conservatorship of DFPS and/or parents who are referred to treatment by DFPS.	**Children and Families:** DFPS protects children by purchasing substance abuse treatment services and drug-testing services for children in the CPS system and their families. **Contracted Service Providers:** DFPS purchases these services from various service providers.
B.1.8: Other CPS Purchased Services. Provide purchased services to treat children who have been abuse or neglected, to enhance the safety and well-being of children at risk of abuse and neglect, and to enable families to provide safe and nurturing home environments for their children.	**Children and Families:** DFPS protects children by purchasing various types of services for children in the CPS system and their families. Services include evaluation of psychological and psychiatric functioning; individual, group, and family therapy, parenting, battering intervention, life skills, etc. **Contracted Service Providers:** DFPS purchases these services from various service providers.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
B.1.9: Foster Care Payments. Provide financial reimbursement for the care, maintenance, and support of children who have been removed from their homes and placed in licensed, verified child care facilities.	**Children in Foster Care:** DFPS provides reimbursement for the care, maintenance, and treatment of children who have removed from their homes. **Contracted Service Providers:** DFPS purchases these services from DFPS foster homes, contracted child-placing agencies, and child care facilities. **External Partners:** The foster care program would not be possible without the 24-hour residential child care providers. DFPS works closely with provider groups and associations.
B.1.10: Adoption/PCA Payments. Provide grant benefit payments for families that adopt foster children with special needs and for relatives that assume permanent managing conservatorship of foster children, and one-time payments for non-recurring costs.	**Children and Families:** DFPS helps ensure a permanent placement for children available for adoption with special needs by providing a monthly subsidy payment to assist with the cost of the child's special needs. DFPS also provides Permanency Care Assistance to relative caregivers that assume permanent managing conservatorship for a child.
B.1.11: Relative Caregiver Payments. Provide monetary assistance for children in the state relative and other designated caregiver program.	**Relative and Other Designated Caregivers:** DFPS provides monetary assistance to relatives and other designated caregivers to help ensure successful, permanent placements for children removed from their homes**.**
C.1.1: Services to At-Risk Youth Program. Provide contracted prevention services for youth ages 10-17 who are in at-risk situations, runaways, or Class C delinquents, and for youth under the age of 10 who have committed delinquent acts. **C.1.2: Community Youth Development Program.** Provide funding and technical assistance to support collaboration by community groups to alleviate family and community conditions that lead to juvenile crime. **C.1.3: Texas Families Program.** Provide community-based prevention services to alleviate stress and promote parental competencies and behaviors that will increase the ability of families to	**Children and Families:** DFPS provides funding for community-based child abuse prevention and juvenile delinquency prevention services to at-risk children and for the families of those children. **Contracted Service Providers:** DFPS contracts with various community-based organizations across the state to deliver all the prevention and early intervention services described in A.2.12 through A.2.17. **Other Agencies:** At-risk prevention services involve participation from the

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
successfully nurture their children. **C.1.4: Child Abuse Prevention Grants.** Provide child abuse prevention grants to develop programs, public awareness, and respite care through community-based organizations. **C.1.5: Other At-Risk Prevention Programs.** Provide funding for community-based prevention programs to alleviate conditions that lead to child abuse/neglect and juvenile crime. **C.1.6**: At-Risk Prevention Program Support. Provide program support for at-risk prevention services.	Texas Education Agency, Texas Juvenile Justice Department **Local Governments:** At-risk prevention services involve participation from local juvenile probation departments. Some prevention services are provided through contracts with local governments. **External Partners:** Overseeing prevention services involves many external partners such as law enforcement agencies, schools, and children's advocate groups.
D.1.1: APS Direct Delivery Staff. Provide caseworkers and related staff to conduct investigations and provide or arrange for services for vulnerable adults. **D.1.2: APS Program Support.** Provide staff, training, automation, and special projects to support a comprehensive and consistent system for the delivery of adult protective services.	**Adults who are over 65 or who have disabilities:** DFPS protects adults who are over age 65 or who have disabilities from abuse, neglect, and exploitation, and providing services to remedy or prevent further abuse. **Persons with mental illness (MI) and/or intellectual disabilities (ID) served by or through providers:** DFPS protects persons who have MI and ID served by or through providers by investigating reports of abuse, neglect, and exploitation. **Other Agencies:** Adult protective services includes support and involvement from DADS, DARS and DSHS. **Local Governments:** Providing adult protective services involves support and participation from city and county health and social services departments, and the Area Agencies on Aging. Also includes, for persons served by providers, participation from Community Centers. **External Partners**: Conducting investigations and providing services involves many external partners, such as law enforcement agencies, the medical sector, the judiciary, faith-based organizations, non-profit social service agencies, advocate groups for adults who

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	are over age 65 or who have disabilities, state and national associations on aging and care for the elderly, and family and friends of APS clients. Also includes many external partners, such as advocacy groups for persons with mental illness and intellectual disabilities, state and national associations for mental health, and family and friends of MI and ID clients.
D.1.3: APS Purchased Emergency Client Services. Provides funds for emergency purchased client services for clients over age 65 or who have disabilities in confirmed cases of abuse, neglect or exploitation.	**Adults who are over 65 or who have disabilities:** DFPS protects adults who are over age 65 or who have disabilities from abuse, neglect, and exploitation, and providing services to remedy or prevent further abuse. **Contracted Service Providers:** DFPS contracts with various service providers to deliver necessary emergency services for APS clients.
E.1.1: Child Care Regulation. Provide a comprehensive system of consultation, licensure, and regulation to ensure maintenance of minimum standards by day care and residential child care facilities, registered family homes, child-placing agencies, and facility administrators, and child-placing agency administrators.	**Children and Families:** DFPS helps ensure the health, safety, and well-being of children in child day care and 24-hour residential child care settings by developing and regulating compliance with minimum standards and investigating reports of abuse and neglect in child care facilities. **Other State Agencies:** Child care regulation involves support and participation by Texas Workforce Commission, DSHS, and other regulatory agencies. **Local Governments:** DFPS regulation of child care facilities involves the network of child care providers managed by local workforce boards. It also includes local health agencies and fire inspectors. **External Partners:** DFPS regulation of child care facilities includes listed family homes, registered child care homes, licensed child care centers and homes,

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	licensed residential child care facilities, and licensed child placing agencies. Other external partners in ensuring safety of children in childcare settings include parents, schools, licensed child care administrators, and children's advocates.
F.1.1: Central Administration. **F.1.2:** Other Support Services. **F.1.3:** Regional Administration. **F.1.4:** IT Program Support.	DFPS provides indirect administrative support for all programs. All stakeholder groups would be included for this group of strategies. Additionally, DFPS employees receive support services under these strategies.
G.1.1: Agency-wide Automated System. Develop and enhance automated systems that service multiple programs (capital projects).	DFPS provides information technology support for all programs. All stakeholder groups would be included for this strategy. Additionally, DFPS employees receive support services under this strategy.

APPENDIX D: CUSTOMER INVENTORY FOR THE DEPARTMENT OF STATE HEALTH SERVICES (DSHS)

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
A.1.1. Public Health Preparedness and Coordinated Services. Provides a strong, flexible public health system necessary to be prepared for and respond to any large scale public health disaster.	**Citizens of Texas:** DSHS is responsible for public health and medical services during a disaster or public health emergency and ongoing surveillance for infectious disease outbreaks with statewide potential such as influenza and foodborne outbreaks. **Other Local, State, and Federal Agencies:** DSHS coordinates with local health departments (LHDs); Texas Division of Emergency Management; Regional Advisory Councils; laboratories and laboratory response networks; first responders; law enforcement; environmental, veterinary, and agricultural laboratories; hospitals; and healthcare systems. **Texas-Mexico Border Residents:** DSHS coordinates and promotes health issues between Texas and Mexico and identifies resources and develops projects that support community efforts to improve border health. **Border Health Partners:** DSHS provides interagency coordination and assistance on public health issues with local border health partners; binational health councils; state border health offices in California, Arizona, and New Mexico; U.S.-Mexico Border Health Commission; U.S. Environmental Protection Agency (EPA) Border 2020 Program; U.S. Department of Health and Human Services (DHHS) Office of Global Affairs, U.S. DHHS Health Resources and Services Administration (HRSA) Office of Border Health; México Secretaria de Salud; and other state and federal agency border programs.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	Public Health Services: DSHS Health Service Regions (HSR) are responsible for ensuring the provision of public health services to communities across Texas where no local health departments has been established or the local health department does not have the capacity or wish to provide a full range of public health services. State and federal funds are used to support our Regions in the prevention of epidemics and spread of disease; protection against environmental hazards; prevention of injuries; promotion of healthy behaviors; and response to disasters.
A.1.2. Health Data and Analysis. Concerns the collection, analysis, and dissemination of health data to aid in monitoring, evaluating, and improving public health. Also includes the maintenance of the basic identity documents pertaining to all Texans, along with the registries that collect health information for research purposes.	**Citizens of Texas:** DSHS provides vital records needed to access benefits and services. DSHS provides case-coordination activities for children identified with elevated blood lead levels. DSHS utilizes data to help address citizen concerns regarding disease in their neighborhoods. DSHS posts facility level data on occurrence of health care-associated infections and preventable adverse events to a public website. DSHS' Texas Cancer Registry collects, maintains, and disseminates cancer data for all Texas residents. The aggregated cancer data that is shared with a diverse group of users and stakeholders contributes towards cancer prevention and control, improving diagnoses, treatment, survival, and quality of life for all cancer patients. **Local Governments:** DSHS provides vital records and health-related disease registry and hospital data for health planning and policy decisions. DSHS maintains and operates a statewide information system, Texas Electronic Registrar (TER), for use by statewide officials responsible for birth and death registration. DSHS receives

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	information from district and county clerks responsible for registering vital event information associated with marriages, divorces, and suits affecting the family. **Funeral Directors, Funeral Home Staff, Medical Directors, and Facilities:** DSHS maintains and operates TER for use by funeral directors and funeral home staff that provide death certificates as part of funeral services and collect demographic data associated with registered deaths. Physicians, justices of the peace, medical examiners, hospitals, and hospices also contribute medical data associated with registration of death events. DSHS TER provides data to researchers and for other public health purposes, including inclusion in national and international documents that discuss and/or report the burden of cancer nationally and/or internationally. **Hospitals, Birthing Centers, and Midwives:** DSHS maintains TER for hospitals, birthing centers, and certified and non-certified midwives that are responsible for registration of birth events. **Schools of Public Health and Universities:** DSHS provides statistical data to researchers to understand causes of diseases and develop prevention and control strategies. **Other External Partners:** DSHS coordinates with the Texas Funeral Directors Association, Texas Medical Association (TMA), Texas Academy of Family Physicians, Texas Midwifery Association, Association of Texas Midwives, County Medical Societies, Texas and New Mexico Hospice Organization, Texas Justice Court Training Center, Texas

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	County Commissioners Court, County and District Clerks' Association of Texas, and Commonwealth Institute of Funeral Service; Texas Hospital Association; Texas Society of Infection Control and Prevention; local chapters of the Association for Professionals in Infection Control and Epidemiology; Texas Medical Association, Texas Tumor Registrars Association, the National Program of Cancer Registries - part of the Centers for Disease Control and Prevention (CDC), and the North American Association of Central Cancer Registries (NAACCR). **Other State Agencies:** DSHS coordinates with the Office of Attorney General, DFPS, DADS, Texas Department of Transportation, Texas Workforce Commission, Department of Assistive and Rehabilitative Services, HHSC, Texas Commission on Environmental Quality, Cancer Prevention and Research Institute of Texas (CPRIT), Texas Department of Housing and Community Affairs, Texas Poison Center Network, Texas Funeral Service Commission, Texas Medical Board, Texas Board of Nursing, Texas Department of Agriculture, and Texas State Commission on Judicial Conduct. **Federal Agencies:** DSHS coordinates with the CDC, National Center for Health Statistics, Social Security Administration, Federal Bureau of Investigations, Food and Drug Administration (FDA), National Institute of Occupational Safety and Health, Centers for Medicare & Medicaid Services (CMS), Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registries, Department of Veteran Affairs, and EPA.
A.2.1. Immunize Children and Adults in Texas. Provides services to prevent, control, reduce, and	**Direct Consumers:** DSHS operates the Texas Vaccine for Children and Adult

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
eliminate vaccine-preventable diseases in children and adults, with emphasis on children under 36 months of age.	Safety Net Program to provide immunizations for eligible children, adolescents, and adults, and educates and performs quality assurance activities with healthcare providers vaccinating these groups. DSHS maintains an electronic vaccine inventory system that enables participating providers to order vaccine stock and report on vaccines administered. DSHS maintains a statewide immunization registry (ImmTrac) that contains millions of immunization records, mostly for children. Healthcare providers use ImmTrac to ensure timely administration of vaccines and to avoid over vaccination. Parents may obtain immunization records for their children. DSHS also conducts surveillance, investigation, and mitigation of vaccine-preventable diseases. **Local Governments:** DSHS provides assistance to LHDs in conducting immunization programs at the local level, including providing immunizations for eligible children, adolescents, and adults; providing immunization education; and assisting with activities to increase immunization coverage levels across Texas. **Schools and Childcare Facilities:** DSHS provides education and technical assistance to school and childcare facilities on school immunization requirements. Additionally, DSHS conducts audits on schools and childcare facilities to ensure that the facilities comply with school immunization requirements. **External Partners:** DSHS works with the Texas Immunization Stakeholder Working Group, which includes representatives from TMA, Texas Pediatric Society, parents, schools, LHDs, pharmacists, nurses, vaccine manufacturers, immunization coalitions, and

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	other organizations with a role in the statewide immunization system. **Other State Agencies:** DSHS works with DFPS and HHSC in the delivery of immunization services.
A.2.2. HIV/STD Prevention. Provides human immunodeficiency virus (HIV)/sexually transmitted disease (STD) surveillance, prevention and service programs, and public education about HIV/STD disease prevention.	**Direct Consumers:** DSHS provides access to HIV treatment and care services, including life-enhancing medications, for low-income, uninsured persons. DSHS also provides ambulatory medical care and supportive services to persons with HIV disease through contracted providers. DSHS contracts to provide HIV testing, linkage to HIV related medical care and behavior change interventions to prevent the spread of HIV and other STDs. DSHS provides testing for STDs, medications for some STDs, and disease intervention and partner services to reduce the spread of STDs. **Local Governments:** DSHS provides assistance to local governments in the delivery of services to assure that persons diagnosed with HIV and high priority STDs are notified and linked to medical care and treatment. Assistance is provided to assure that partners of persons newly diagnosed with HIV and high priority STD are notified and offered testing services. DSHS provides capacity building and technical assistance/training services to LHDs providing HIV/STD prevention and treatment and care services. DSHS works with LHDs to promote HIV/STD as a health and prevention priority among medical providers and the community at large. DSHS provides local leaders and groups across Texas with information on the size and scope of HIV and STD cases in their communities, with HIV/STD-specific strategic planning tools, and with best risk reduction practices to support creation of

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	HIV/STD prevention and services action plans. **Community Based Organizations:** DSHS provides capacity building and technical assistance/training services to contracted providers providing HIV/STD prevention and treatment and care services. **Committee:** The Texas HIV Medication Advisory Committee advises DSHS about the HIV Medication Program formulary and policies.
A.2.3. Infectious Disease Prevention, Epidemiology and Surveillance. Plays a vital role in defining, maintaining, and improving public health response to disasters, disease outbreaks, or healthcare-associated infections and in creating plans for effective disease prevention.	**Citizens of Texas:** DSHS coordinates disease surveillance and outbreak investigations and provides information on the occurrence of disease and prevention and control measures. DSHS conducts surveillance for and investigations of infectious diseases, recommends control measures, and implements interventions. In addition, DSHS provides information on infectious disease prevention and control to the public through the website and personal consultation. DSHS facilitates the distribution of rabies biologics to persons exposed to rabies, provides Animal Control Officer training opportunities, inspects animal rabies quarantine facilities, immunizes wildlife that can transmit rabies to humans, mobilizes community efforts such as pet neutering programs through the Animal Friendly grant, and maintains an investigative response team. **Local Governments:** DSHS coordinates infectious disease prevention, control, epidemiology, and surveillance activities with LHDs. **Other State and Federal Agencies:** DSHS collaborates daily with the CDC to maintain consistency with national guidance on infectious disease surveillance,

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	investigation, and mitigation. DSHS serves as the lead on a cooperative project with U.S. Department of Agriculture and Texas Military Forces. Other stakeholders are the Texas Animal Health Commission, Texas Parks and Wildlife Department, Texas Veterinary Medical Diagnostic Laboratory, U.S.-Mexico Border Health Commission, Rotary International, CDC, FDA, HRSA, schools of public health in Texas, voluntary agencies, HHSC, and federal Office of Refugee Resettlement. **Medical Community:** DSHS provides information and consultation to the human and veterinary medical communities and to healthcare professionals personally and through professional organizations, presentations and posters at scientific meetings, and peer-reviewed publications.
A.2.4 TB Surveillance & Prevention. Provides Tuberculosis (TB) disease prevention education; treatment information and options; health promotion and public awareness campaigns, and surveillance of existing diseases.	**Citizens of Texas:** DSHS establishes disease surveillance and outbreak investigations processes and provides information on the occurrence of TB disease in communities across Texas. DSHS implements TB disease control measures to promote adherence to treatment. DSHS also ensures that all residents of Texas who are diagnosed with TB or Hansen's disease receive treatment regardless of ability to pay for services. In addition, DSHS provides information to the public on TB prevention and control. Hansen's disease and refugee health assessment services through its website. Phone consultations are also provided to the public on TB, Hansen's disease and refugee health services. DSHS provides health assessment services for newly arriving refugees and other program eligible clients such as certified victims of trafficking. Cuban parolees, asylees, and persons with

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	special immigrant visas. **Local Government:** DSHS contracts with local health departments to provide outpatient clinical and public health services for TB, refugee health assessments and Hansen's disease management. DSHS works with DSHS health service regions and local health department's providers on TB binational projects and other special projects targeting individuals and groups at high risk for TB. DSHS provides capacity building, technical assistance, and training services to contracted providers on TB, Hansen's disease and refugee health assessment activities. DSHS works in collaboration with local health departments and health service regions to evaluate TB screening, reporting and case management activities conducted by 154 local jails statewide. **State Agencies:** DSHS collaborates with Texas Commission on Jail Standards to ensure jails meeting the criteria for developing and maintaining a TB screening program are upheld. DSHS collaborates with Texas Department of Criminal Justice on TB screening and reporting activities. **Federal Agencies:** DSHS collaborates with the CDC. Office of Refugee Resettlement, the National Hansen's Disease Program, Bureau of Prisons, Immigration Customs Enforcement, U.S. Marshal's Office on disease surveillance, reporting and management. **Medical Community:** DSHS provides consultation services to healthcare professionals on TB, Hansen's disease and refugee health assessment activities. DSHS partners with Heartland National TB

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	Center, a CDC Regional Training and Medical Consultation Center to provide trainings to health care professionals and to maintain an educated TB work force. DSHS also participates in professional organizations including conducting presentations and presenting posters at scientific meetings and submitting peer-reviewed publications.
A.3.1. Health Promotion and Chronic Disease Prevention. Provides health promotion and wellness activities for the elimination of health disparities and the reduction of primary/secondary risk factors for certain common, disabling chronic conditions that place a large burden on Texas healthcare resources.	**Citizens of Texas:** DSHS provides awareness and educational resources/materials for diabetes, Alzheimer's disease, cancer, asthma, kidney disease and cardiovascular disease (CVD). DSHS provides child safety seats to low income families with children less than eight years of age. DSHS provides support to communities for planning and implementing evidence-based obesity prevention interventions through policy and environmental change. **Councils, Task Forces, and Collaboratives:** DSHS provides administrative support to the Texas Diabetes Council, Texas Council on Alzheimer's Disease and Related Disorders, Texas Council on CVD and Stroke, Texas CVD and Stroke Partnership, Texas School Health Advisory Council, Stock Epinephrine Advisory Committee and Cancer Alliance of Texas. **Healthcare Professionals:** DSHS provides toolkits that include professional and patient education materials featuring self-management training, minimum standards of care, and evidence-based treatment algorithms. **Community Diabetes Projects:** DSHS contracts with LHDs, community health centers, and grassroots organizations to

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	establish programs for promoting wellness, physical activity, weight and blood pressure control, and smoking cessation for people with or at risk for diabetes. **Schools and Communities:** DSHS provides technical assistance on the care of students with or at risk for chronic disease. DSHS provides child safety seats and education to community partners that assist in the distribution of the safety seats to low income families and trains nurses, police officers, and other community members to be nationally certified child passenger safety technicians. **State Agencies:** DSHS works with state agency worksite wellness coordinators to implement health promotion and wellness activities in Texas state agencies.
A.3.2. Reducing the Use of Tobacco Products Statewide. Provides comprehensive tobacco prevention and control activities.	**Citizens of Texas**: DSHS plays a leadership role in educating the public about the importance of tobacco prevention and cessation. DSHS also provides cessation counseling services to all Texas residents. **Healthcare Providers:** DSHS provides training and resources for healthcare providers to implement best practices for treating tobacco dependence in multiple healthcare settings. **Contracted Services:** DSHS contracts with a media firm; a national Quitline service provider; state institutions of higher education; and local coalitions to implement comprehensive tobacco prevention, cessation, and environmental change policies.
A.3.3. Abstinence Education. Provides abstinence education to priority populations to decrease the birth rate among teens, decrease the proportion of adolescents engaged in sex, decrease the incidence	**Adolescents and Parents:** DSHS provides abstinence education in Spanish and English through brochures, toolkits, workbooks, curricula, and online as well as service

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
of sexually transmitted infections in adolescents, and increase adolescents' interest in further education.	learning opportunities and leadership summit opportunities for youth in grades 5-12, and resources for parents in Spanish and English online and through booklets and DVDs. **Contractors:** DSHS contracts with providers to provide abstinence education curricula and service learning projects during in-school and after-school interventions. **School Districts:** DSHS provides workshops, webinars, trainings, toolkits, brochures, and workbooks for school districts across Texas. **Community, Faith-based, and Health Organizations:** DSHS provides toolkits, brochures, and workbooks for organizations.
A.3.4. Kidney Health Care. Provides healthcare specialty services and the infrastructure required to determine client eligibility and to process claims.	**Direct Consumers:** DSHS provides benefits to persons with end-stage renal disease who are receiving a regular course of renal dialysis treatments or have received a kidney transplant. **External Partners:** External partners include professional associations, including the End Stage Renal Disease Network and the Texas Kidney Foundation, to provide information and training and to receive information about the population served.
A.3.5. Children with Special Health Care Needs. Provides services to eligible children with special healthcare needs in the areas of early identification, diagnosis, rehabilitation, family support, case management, and quality assurance.	**Direct Consumers:** DSHS provides services to children with special health care needs and their families and people of any age with cystic fibrosis. Services are provided through community-based contractors, entities that provide direct healthcare services and case management. DSHS staff also provides case management. **External Partners:** DSHS actively participates on a variety of advisory groups

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	including but not limited to the Children's Policy Council and the Texas Council for Developmental Disabilities. DSHS interacts with professional organizations, including Children's Hospital Association of Texas, Texas Hospital Association (THA), TMA, and Texas Pediatric Society, and advocacy/support groups, including Texas Parent to Parent, Every Child, Inc., and Disability Rights Texas. DSHS facilitates the Medical Home Workgroup, Transition Workgroup, and participates in the STAR Kids Advisory Council, the Texas Respite Coalition, the statewide Community Resource Coordination Group (CRCG), and the ECI Advisory Committee.
A.3.6. Epilepsy Services. Provides treatment support and/or referral assistance to reduce disability and premature death related to epilepsy.	**Direct Consumers:** DSHS provides clinical and support services through contracted providers to Texas residents with epilepsy or seizure-like symptoms who meet specific eligibility requirements. **Contracted Providers:** DSHS contracts with a university medical center, hospital district, and nonprofit organizations for epilepsy services. Local health entities, schools of public health, and universities may be contracted providers. **External Partners:** DSHS interacts with professional organizations, including TMA, THA, and with statewide epilepsy entities.
A.3.7. Hemophilia Services. Provides treatment support and/or referral assistance to reduce disability and premature death related to hemophilia.	**Direct Consumers**: DSHS provides financial assistance for people with hemophilia to pay for their blood factor replacement products. **Contracted Providers:** DSHS contracts with pharmacies for hemophilia services. Local health entities, schools of public health, and universities may be contracted

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	providers. **External Partners:** DSHS interacts with professional organizations, including hemophilia treatment centers, TMA, and THA, and with statewide hemophilia networks.
A.4.1. Laboratory Services. Provides laboratory testing to diagnose and investigate community health problems and health hazards.	**Citizens of Texas:** DSHS screens pregnant women for infectious diseases; tests for HIV, STD, and TB; screens for lead in children; tests bay water and milk samples for contamination; tests for rabies; screens every newborn for 53 disorders; and identifies organisms responsible for disease outbreaks throughout Texas. **Other Local, State, and Federal Agencies:** DSHS coordinates with LHDs and their laboratories; laboratories that are part of CDC Laboratory Response Network; first responders; law enforcement; environmental, veterinary, and agricultural laboratories; vector control programs; and animal control programs. **Public Water Systems:** DSHS provides testing of water samples as part of the EPA Safe Drinking Water Act.
B.1.1. Provide WIC Services: Benefits, Nutrition Education & Counseling. Provides nutrition education and food assistance to eligible infants, children, and women and provides breastfeeding promotion and support. Also provides nutrition, physical activity, and obesity prevention; public health surveillance; planning and policy development; funding for community-based interventions; facilitation of state/local coalitions to promote nutrition; training for medical and public health professionals; and public education.	**Direct Consumers:** DSHS provides services to low-income pregnant and post-partum women, infants, and children up to age five who meet certain eligibility requirements. **Citizens of Texas:** DSHS provides funding and support to communities through a competitive process to implement population level, evidence-based approaches to obesity prevention. **Contracted Providers:** DSHS contracts with LHDs, public health districts, hospitals, and nonprofit organizations to provide the

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	Women, Infants, and Children (WIC) Program. **External Partners, Healthcare Professionals, and Other State Agencies:** DSHS provides subject matter expertise to a variety of external partners.
B.1.2. Women and Children's Health Services. Provides direct, enabling, population-based, and infrastructure-building services for women and children.	**Direct Consumers:** DSHS provides contracted clinical, educational, and support services to Texas residents who meet specific eligibility requirements. DSHS provides preventive oral health services to children in low-income schools and provides training and certification for vision and hearing screening. In addition, DSHS makes audiometers available to schools and day care centers for their staff to conduct screenings. DSHS also provides preventive and primary care, medical and limited dental services, and case management to low-income pregnant women and children through contracts with Title V funds. Limited genetics services are also provided through contracts. DSHS notifies primary care physicians and families of newborns with out-of-range newborn screening results to ensure clinical care coordination to prevent development delays, intellectual disability, illness, or death. DSHS also provides education to providers and the public regarding genetics. **Contracted Providers:** DSHS provides professional education to dental, medical, and case management providers through online provider education and in-person training opportunities. DSHS contracts with nonprofit organizations including LHDs, hospital districts, university medical centers, federally qualified health centers (FQHCs), and other community-based organizations.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	Certified Individuals: DSHS provides oversight of the training and certification requirements for promotores/community health workers and training instructors. **Texas School Health Advisory Committee:** DSHS provides administrative support to this advisory committee. **Schools:** DSHS contracts with entities that provide primary and preventive services through school-based health centers. DSHS also provides training and technical assistance to school administrators, school nurses, and parents on the provision of health services within the school setting. **Other State Agencies:** DSHS provides subject matter expertise, including research and data analysis, on topics related to maternal and child health populations. DSHS also collaborates with the CPRIT on cancer-related activities. Under authority of Title XIX of the SSA, Chapters 22 and 32 of the Human Resource Code and an IAC with HHSC, DSHS provides for administrative functions related to periodic medical and dental checkups for Medicaid-eligible children 0 through 20 years of age and case management for children 0 through 20 years of age and pregnant women with health risks or health conditions. **External Partners:** DSHS interacts with the American Cancer Institute, Susan G. Komen Foundation, LIVESTRONG Foundation, Texas Pediatric Society, Texas Dental Association, TMA, March of Dimes, Children's Hospital Association of Texas, Head Start programs, independent school districts, and healthcare providers.
B.1.3. Community Primary Care Services. Provides services to the medically uninsured, underinsured, and indigent persons who are not	**Direct Consumers:** DSHS provides clinical services through contracted providers to Texas residents who meet specific eligibility

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
eligible to receive services from other funding sources; assesses the need for health care; designates parts of the state as health professional shortage areas; recruits and retains providers to work in underserved areas; identifies areas that are medically underserved; and provides funding to communities for improved access to primary medical/dental/behavioral health care.	requirements. **Contracted providers:** DSHS contracts with nonprofit organizations such as LHDs, hospital districts, university medical centers, FQHCs, and other community-based organizations. **Local Health Departments:** DSHS may recommend areas where local health entities operate for federal designation as Health Professional Shortage Areas and Medically Underserved Areas. **Schools of Public Health and Universities:** DSHS partners with these entities in recruitment activities for the National Health Service Corps and Texas Conrad 30 J-1 Visa Waiver Program. **Other Organizations:** DSHS works with communities and nonprofit organizations to develop and expand FQHCs in Texas.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
B.2.1. Mental Health Services for Adults. Provides community services designed to allow adults with mental illness to attain the most independent lifestyle possible.	**Contracted Services:** DSHS contracts with local mental health authorities to provide services to adults with diagnoses such as schizophrenia, bipolar disorder, major depression, post-traumatic stress disorder, schizoaffective disorder, obsessive-compulsive disorder, anxiety disorder, attention deficit disorder, delusional disorder, and eating disorders who are experiencing significant functional impairment. Additionally, DSHS contracts with community behavioral health providers to provide mental health services. Community services for adults may include: psychiatric diagnosis; pharmacological management; training; and support; education and training; case management; supported housing and employment; peer services; therapy; and rehabilitative services.
B.2.2. Mental Health Services for Children. Provides community services for children and adolescents ages 3-17.	**Contracted Services:** DSHS contracts with local mental health authorities to provide services to children ages 3–17 with serious emotional disturbance (excluding a single diagnosis of substance use disorder, intellectual or developmental disability, or autism spectrum disorder) who have a serious functional impairment or who: 1) are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms, or 2) are enrolled in special education because of a serious emotional disturbance. Additionally, DSHS contracts with community behavioral health providers to provide mental health services. Community services for children may include: community-based assessments, including the development of inter-disciplinary, recovery oriented treatment plans, diagnosis, and evaluation services; family support services, including respite

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	care; case management services; pharmacological management; counseling; and skills training and development.
B.2.3. Community Mental Health Crisis Services. Ensures statewide access to competent rapid response services, avoidance of hospitalization, and reduction in the need for transportation.	**Contracted Services:** DSHS contracts with local mental health authorities to provide crisis services to persons whose crisis screening and/or assessment indicate that they are an extreme risk of harm to themselves or others in their immediate environment or to persons believed to present an immediate danger to self or others or their mental or physical health is at risk of serious deterioration. Additionally, DSHS contracts with community behavioral health providers to provide mental health services. Crisis services are designed to provide timely screening and assessment to individuals in crisis to divert them from unnecessary treatment in restrictive environments such as jails, emergency rooms, and state hospitals. Statewide crisis services include crisis hotlines, mobile crisis outreach teams and crisis facilities.
B.2.4. NorthSTAR Behavioral Health Waiver. Provides managed behavioral healthcare services to persons residing in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwell counties.	NorthSTAR ceases to exist as of 12/31/2016. Beginning January 1, 2017, funds to provide services, other than Medicaid behavioral health services, previously available through NorthSTAR, will be allocated to the North Texas Behavioral Health Authority (NTBHA) and to the local behavioral health authority (LBHA) serving Collin County, an entity known as LifePath Systems. Program support will be continued for approximately 6-12 months after the start of the new system to ensure a smooth transition to the new model of service delivery.
B.2.5. Substance Abuse Prevention, Intervention and Treatment. Establishes, develops, and	**Contracted Services:** DSHS contracts with local community providers to provide

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implements coordinated and integrated prevention, treatment, and recovery substance abuse services.	substance abuse prevention, intervention, and treatment services. Substance Abuse Prevention is targeted to school-age children and young adults. HIV Outreach and HIV Early Intervention programs provide information and education for substance abusing adults at risk for HIV or who are HIV positive. Pregnant, Post-Partum Intervention Services provide case management, education, and support for pregnant and post-partum women at risk for substance abuse. DSHS contracts with state licensed programs to deliver treatment services to adolescents and adults who meet DSM-V criteria for substance abuse or dependence. Each region provides a continuum of care that includes outreach, screening, assessment, and referral; specialized services for females; residential and outpatient treatment for adults and youth; pharmacotherapy; and treatment for co-occurring disorders. DSHS also funds recovery support services such as housing, employment, and recovery coaching in order to develop long-term recovery in communities around the state.
B.3.1. EMS and Trauma Care Systems. Develops a statewide emergency medical services (EMS) and trauma care system that is fully coordinated with all EMS providers and hospitals.	**Citizens of Texas:** DSHS insures a coordinated statewide trauma system and designates trauma and stroke facilities in Texas.
B.3.2. Indigent Health Care Reimbursement (UTMB). Provides funds for unpaid healthcare services to expand access to healthcare.	**University of Texas Medical Branch at Galveston (UTMB):** DSHS transfers funds for unpaid healthcare services provided to indigent patients.
B.3.3. County Indigent Health Care Services. Provides reimbursement upon request to counties not fully served by a public hospital or a hospital district once they have expended 8% of their General Revenue Tax Levy on indigent health care.	**Local Governments:** DSHS provides technical assistance to counties regarding program compliance and assistance with Supplemental Security Income and Medicaid claim submission.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
C.1.1. Texas Center for Infectious Disease (TCID). Provides for more than one level of inpatient and outpatient care, education, and other services for patients with TB or Hansen's disease.	**Direct Consumers:** DSHS directly provides inpatient and outpatient care, education, and other services for patients with TB or Hansen's disease. Patients are admitted by court order or clinical referral for TB, Hansen's disease, or other diseases that are too severe for treatment elsewhere.
C.1.2. Rio Grande State Outpatient Clinic. Provides services, either directly or by contract with one or more public or private health care providers or entities, to the residents of the Lower Rio Grande Valley.	**Direct Consumers:** DSHS provides outpatient primary health care, including outpatient primary care and internal medicine clinic; pharmacy and patient drug assistance program; cancer screening; women's health clinic (sexually transmitted disease screening); medical nutrition therapy; and diabetes education and lab services to indigent adult residents throughout a four-county service area (Cameron, Hidalgo, Willacy, and Starr counties). DSHS operates the South Texas Public Health Laboratory on the campus of RGSC to partially serve the public health laboratory needs for Health Service Region 11.
C.1.3. Mental Health State Hospitals. Provides specialized inpatient services in state psychiatric facilities.	**Direct Consumers:** DSHS directly provides statewide access to court-directed specialized inpatient services in nine state psychiatric hospitals (including a psychiatric unit at the Rio Grande State Center) for persons who are seriously mentally ill and are a risk to themselves or others or show a substantial risk of mental or physical deterioration of the person's ability to function independently. Individuals are on civil or forensic judicial commitments or are accepted on voluntary admissions. DSHS also provides services at the Waco Center for Youth, a psychiatric residential treatment center that admits children ages 13-17 who have a diagnosis of being emotionally disturbed, who have a history of behavior adjustment problems, and who need a structured treatment program in a

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	psychiatric residential facility.
C.2.1. Mental Health Community Hospitals. Provides inpatient services in response to local needs through small psychiatric hospitals.	**Contracted Services:** DSHS contracts with local mental health authorities, county governments and universities to provide specialized inpatient services in their communities for persons who are seriously mentally ill and are a risk to themselves or others or show a substantial risk of mental or physical deterioration of the person's ability to function independently. Individuals are on civil or forensic judicial commitments or are accepted on voluntary admissions.
D.1.1. Food (Meat) and Drug Safety. Licenses, inspects, and regulates manufacturers, producers, wholesale distributors, food managers and workers, harvest areas, meat and poultry processors, rendering facilities, and retailers of foods, drugs, and medical devices.	**Citizens of Texas:** DSHS protects citizens from contaminated, adulterated, and misbranded foods by enforcing food safety laws and regulations and investigating foodborne illness outbreaks to identify sources of contamination. DSHS also protects citizens from unsafe drugs, medical devices, cosmetics, and tattoo and body-piercing procedures through regulation. DSHS protects school age children by inspecting school cafeterias.
D.1.2. Environmental Health. Protects the public from exposure to asbestos, lead-based paints, hazardous chemicals and other agents through various means including licensing, inspection, investigation, collection and dissemination of data, enforcement, and consultation.	**Citizens of Texas:** DSHS provides protection and handles compliance over a broad range of commonly used consumer items including automotive products, household cleaners, polishes and waxes, paints and glues, infant items, and children's toys. DSHS also protects and promotes the physical and environmental health of Texans from asbestos, mold, and lead. DSHS protects children attending private and university-based summer youth camps by requiring completion of certain trainings and inspections.
D.1.3. Radiation Control. Ensures the effective regulation of all sources of radiation.	**Citizens of Texas:** DSHS prevents unnecessary radiation exposure to the public through effective licensing, registration,

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	inspection, enforcement, and emergency response.
D.1.4. Health Care Professionals. Ensures timely, accurate issuance of licenses, registrations, certifications, permits, or documentations and investigates complaints and takes enforcement action as necessary to protect the public.	**Citizens of Texas:** DSHS regulates and sets standards for allied health professions, including counselors, emergency medical professionals, social workers, midwives, massage therapists, sanitarians, athletic trainers, medical radiologic technologists, and fitters and dispensers of hearing instruments.
D.1.5. Health Care Facilities. Assures quality healthcare delivery by regulating health facilities/entities and organizations that provide care and services to the Texas consumers.	**Citizens of Texas:** DSHS monitors the healthcare delivery in regulated healthcare facilities through licensing and inspection activities to assure high quality care is provided in hospitals, abortion facilities, birthing centers, psychiatric facilities, ambulatory surgical centers, end stage renal disease facilities, and free standing emergency medical care facilities.
D.1.6. Texas.gov Estimated and Nontransferable. Establishes a common electronic infrastructure through which Texas citizens, state agencies, and local governments are able to register and renew licenses.	**Regulated Entities:** DSHS is statutorily permitted to increase occupational license, permit, and registration fees imposed on licensees by an amount sufficient to cover the cost of the subscription fee charged by TexasOnline.
E.1.1. Central Administration.	**DSHS Employees:** DSHS provides administrative support for DSHS employees and programs.
E.1.2. Information Technology Program Support.	
E.1.3. Other Support Services.	
E.1.4. Regional Administration.	
F.1.1. Laboratory (Austin) Bond Debt. Pays debt service on special revenue bonds issued to build a laboratory and parking structure.	**Citizens of Texas**: DSHS provides testing at the Austin laboratory to diagnose and investigate community health problems and health hazards.
F.1.2. Capital Repair and Renovation: Mental Health Facilities. Funds the necessary repair, renovation, and construction projects required to	**Direct Consumers:** DSHS spends general obligation bond funds on state mental hospital buildings that are in need of

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
maintain the state's psychiatric hospitals at acceptable levels of effectiveness and safety.	ongoing repairs and maintenance. Projects include compliance with life safety and accessibility codes; physical plant changes that help prevent suicide; utility repairs; grounds upkeep; hazardous material remediation and abatement; and roofing, heating, ventilation, and air conditioning repairs.
G.1.1. Texas Civil Commitment Office. Performs the duties related to the sexually violent predator civil commitment program.	The civil commitment of sexually violent predators function was transferred to a new agency, the Texas Civil Commitment Office, effective September 1, 2015.

APPENDIX E: CUSTOMER INVENTORY FOR THE HEALTH AND HUMAN SERVICES COMMISSION (HHSC)

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
A.1.1 Enterprise Oversight and Policy. Provide leadership and direction to achieve an efficient and effective health and human services system.	**Oversight agencies and Legislative Leadership**: HHSC coordinates and monitors the use of state and federal money received by HHS agencies; reviews state plans submitted to the federal government; monitors state health and human services agency budgets and programs, and makes recommendations for budget transfers; conducts research and analyses on demographics and caseload projections; and directs an integrated planning and budgeting process across five HHS agencies. **Other HHS Agencies:** HHSC provides the leadership to assist the HHS agencies in developing customer-focused programs and policy initiatives that are relevant, timely and cost-effective. **Citizens of Texas:** HHSC ensures that state and federal funds allocated to HHS agencies are coordinated and monitored, and spent in the most efficient manner.
A.1.2. Integrated Eligibility and Enrollment Provide accurate and timely eligibility and issuance services for financial assistance, medical benefits, and food stamps**.**	**Children & Families:** The functions involved in both centralizing and conducting eligibility determination for HHS programs will apply to children and families seeking to participate in the Medicaid, CHIP, TANF, SNAP, Texas Women's Health Program and other health and human services programs.
A.2.1. Consolidated System Support. Improve the operations of health and human service agencies through coordinated efficiencies in business support functions.	**Other HHS Agencies.** HHSC provides the leadership for consolidating across the system the functions of: information technology, human resources, civil rights, procurement, ombudsman and other

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	services, e.g. facility management and leasing and regional operations.
B.1.1. Aged and Medicare-Related. Provide medically necessary health care in the most appropriate, accessible, and cost effective setting to aged and Medicare-related Medicaid-eligible persons.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides health care to Medicaid aged and Medicare-related persons. **Managed Care Organizations (MCO)/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
B.1.2. Disability-Related. Provide medically necessary health care in the most appropriate, accessible, and cost effective setting to disability-related Medicaid-eligible adults and children.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides health care to eligible disability-related adults and children. **Managed Care Organizations (MCO)/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
B.1.3. Pregnant Women. Provide medically necessary health care in the most appropriate, accessible, and cost effective setting to Medicaid-eligible pregnant women.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides health care to women who are pregnant and eligible for Medicaid. **Managed Care Organizations (MCO)/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
B.1.4. Other Adults. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to eligible TANF-level adults, medically needy, and other adults who are principally income-level eligible (non-pregnant, non-	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides health care to eligible TANF-level adults, medically needy, and other adults who are principally income-level eligible.

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
Medicare, non-disability-related).	**Managed Care Organizations (MCO)/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
B.1.5. Children. Provide medically necessary health care in the most appropriate, accessible, and cost effective setting to newborn infants and Medicaid eligible children who are neither disability-related nor Medicare eligible.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides health care to Medicaid eligible child recipients.
B.2.1. Non-Full Benefit Payments. Provide medically necessary health care to Medicaid eligible recipients for certain services not covered under the insured arrangement including: federally qualified health centers, undocumented persons, school health, and related services.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides health care to Medicaid eligible recipients for specific services not covered. **Managed Care Organizations (MCO)/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
B.2.2. Medicaid Prescription Drugs. Provide prescription medications to Medicaid-eligible recipients as prescribed by their treating physician.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides prescription medication benefits to Medicaid recipients. **Managed Care Organizations (MCO)/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
B.2.3. Medical Transportation. Support and reimburse for non-emergency transportation assistance to individuals receiving medical assistance.	**Medicaid Consumers:** HHSC provides transportation for Medicaid recipients. **Providers:** The Medical Transportation Program contracts with Managed Transportation Organizations (MTOs) and Full Risk Brokers (FRBs) for the provision of medical transportation services. The

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	program sets policy and provides oversight for the services.
B.2.4. Health Steps (EPSDT) Dental. Provide dental care in accordance with federal mandates to Medicaid eligible children.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides access to periodic dental exams, diagnosis, prevention and treatment of dental disease to Medicaid eligible children. **Managed Care Organizations (MCO)/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
B.2.5. Medicare Payments. Provide accessible premium-based health services to Medicaid-eligible aged and disability related persons who are also eligible for Title XVIII Medicare coverage.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides premium-based health services to Medicaid-eligible aged and disability related persons who are also eligible for Title XVIII Medicare coverage. **Managed Care Organizations (MCO)/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
B.2.6. Transformation Payments. Maximize federal funding to provide supplemental Medicaid reimbursement for uncompensated care and delivery system reform incentives under the 1115 waiver. Historically, provide children's hospital Upper Payment Limit match.	**Hospitals/Providers:** States may receive federal funding to provide hospitals supplemental payments to cover inpatient and outpatient services that exceed regular Medicaid rates.
B.3.1. Medicaid Contracts and Administration. Administer efficient and effective Medicaid program, set the overall policy direction of the state Medicaid program, manage interagency initiatives to maximize federal dollars, and provide resources for client services delivered by other HHS agencies.	**Other HHS Agencies.** HHSC provides the leadership and policy planning for administration of the state Medicaid Office across the HHS system.
C.1.1. CHIP. Provide health care to uninsured	**Federal Government:** HHSC

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
children who apply and are determined eligible for insurance through CHIP. **C.1.2. CHIP Perinatal Services** Provide health care to perinates whose mothers apply and are determined eligible for insurance through CHIP. **C.1.3. CHIP Prescription Drugs.** Provide prescription medication to CHIP-eligible recipients (includes all CHIP programs as their recipients), as provided by the treating physician. **C.1.4. CHIP Contracts and Administration.** Administer efficient and effective CHIP program, including contracted administration, and set overall policy direction of CHIP programs.	Medicaid/CHIP division provides direction, guidance, and policy making for the Children's Health Insurance Program, a federal program administered through states. **Managed Care Organizations:** The HHSC Medicaid/CHIP division contracts with Managed Care Organizations for the provision of the Children's Health Insurance Program. The Medicaid/CHIP division sets policy and provides oversight for the CHIP program. **Children and Families:** The CHIP program exists to serve Texas children and families, providing health insurance to children in families with incomes up to 200% of the federal poverty level.
D.1.1. TANF (Cash Assistance) Grants. Provide TANF grants to low-income Texans.	**Children and Families.** The TANF grants provide capped entitlement services, non-entitlement services, one-time payments, child support payments and payment support for grandparents to children and families.
D.1.2. Refugee Assistance. Assist refugees in attaining self-sufficiency through financial, medical, and social services, and disseminate information to interested individuals.	**Children and Families.** HHSC's Office of Immigration and Refugee Affairs contracts with local agencies to provide refugee clients with services that assist refugees to attain self-sufficiency and integration to their new communities through six main programs. These programs are Refugee Cash Assistance, Refugee Medical Assistance, Refugee Social Services, Special Project Grants, Unaccompanied Refugee Minor, and the Refugee Health Screening programs.
D.1.3. Disaster Assistance. Provide disaster assistance to victims of federally-declared natural disasters.	**Citizens of Texas impacted by disasters:** Emergency Services Program serves as the lead for the administration of federal-funded Other Needs Assistance and

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	Disaster Case Management Programs.
D.2.1. Family Violence Services. Provide emergency shelter and support services to victims of family violence and their children, educate the public, and provide training and prevention support to institutions and agencies.	**Children and Families.** HHSC's Family Violence Program contracts with local agencies to provide shelter, nonresidential, and special nonresidential services. Shelter centers' services include, but are not limited to, 24-hour emergency shelter, 24-hour crisis hotline services, referrals to existing community services, community education and training, emergency medical care and transportation, intervention, educational arrangements for children, cooperation with criminal justice officials, and information regarding training and job placement. Nonresidential centers provide the same services as shelter centers with the exception of the 24-hour emergency shelter component. Special nonresidential services address unmet needs or underserved populations such as immigrants or populations with limited English proficiency.
D.2.2. Alternatives to Abortion. Provide pregnancy support services that promote childbirth for women seeking alternatives to abortion.	**Pregnant Women and Children:** HHSC contracts for the delivery of pregnancy support services. These services include information regarding pregnancy and parenting (brochures, pamphlets, books, classes, and counseling), referrals to existing community services and social service programs (childcare services, transportation, low-rent housing, etc.), support groups in maternity homes, and mentoring programs (classes on life skills, budgeting, parenting, counseling, and obtaining a GED).
D.2.3. Texas Women's Health Program. Provide low-income women with family planning services, related health screenings, and birth control.	**Non-Pregnant Low Income Women:** HHSC provides family planning services, related health screening, and birth control to low-income women who are 18 through 44 years of age. Providers are required to complete a TWHP certification every year

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	they participate.
D.2.4. Child Advocacy Programs. Provide child advocacy centers and court-appointed volunteer advocate programs statewide.	**Children.** HHSC contracts with a statewide organization to provide training, technical assistance, evaluation services, and funds administration to support local children's advocacy center programs and court-appointed volunteer advocate programs.
E.1.1. Central Program Support.	**HHS Employees.** HHSC provides central support services for HHS employees. Services include accounting, budget, and contract and grant administration, internal audit, external relations and legal.
E.1.2. IT Program Support.	**HHS Employees.** HHSC provides central information resource management and support services for HHS employees.
E.1.3. Regional Program Support.	**Other HHS Agencies:** HHSC provides the leadership to assist the HHS agencies in developing in providing to support to regional programs. **Citizens of Texas:** HHSC ensures that state and federal funds allocated to HHS agencies are coordinated and monitored, and spent in the most efficient manner.
F.1.1. Texas Integrated Eligibility Redesign System (TIERS) and Eligibility Technologies. Texas TIERS re-design system and eligibility supporting technology capital.	**Other HHS Agencies:** HHSC provides the leadership to assist the HHS agencies in developing the TIERS system. **Children & Families:** HHSC ensures the accessibility of TIERS to children and families across Texas.
G.1.1. Office of Inspector General (OIG). Eliminate fraud, abuse, and waste in HHS programs.	**Citizens of Texas/Taxpayers:** OIG serves as the lead agency for the investigation of fraud, abuse and waste in health and human services; and administers the Medicaid Fraud and Abuse Detection System technology services contract, which uses technology to identify and

STRATEGY (As currently listed in ABEST as of March 2016)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	deter fraud, abuse and waste in the Medicaid program throughout the state. **Medicaid Providers:** OIG provides training to Medicaid providers on how to detect, prevent and report Medicaid provider fraud; and provides training on Resource Utilization Group for nursing facilities. **Medicaid Consumers:** OIG investigates fraud, abuse and waste in health and human services-related programs, ensuring integrity and efficiency in programs and the highest quality services for beneficiaries. **Residents of Facilities:** OIG monitors Utilization Review activities in Medicaid contract hospitals to ensure program integrity and improve the quality of services delivered to residents of Medicaid facilities.

APPENDIX F: GLOSSARY OF ACRONYMS

AAA – Area Agency on Aging

ACF – Administration for Children and Families

ADL – Activities of Daily Living

AHRQ –Agency for Healthcare Research and Quality

AMH – Adult Mental Health

APS – Adult Protective Services

AR – Alternative Response

ASN – Adult Safety Net

BET – Business Enterprises of Texas

CAHPS® – Consumer Assessment of Healthcare Providers and Systems

CDC – Centers for Disease Control and Prevention

CEA – Consumer and External Affairs

CFCIP – John H. Chafee Foster Care Independence Program

CHIP – Children's Health Insurance Program

CLS – Community Living Supports

CMS – Centers for Medicare and Medicaid Services

CPRIT – Cancer Prevention and Research Institute of Texas

CPS – Child Protective Services

CRS – Consumer Rights and Services

CSHCN – Children with Special Health Care Needs

CVD - Cardiovascular Disease

DADS – Department of Aging and Disability Services

DARS – Department of Assistive and Rehabilitative Services

DBS – Division for Blind Services

DFPS – Department of Family and Protective Services

DRS – Division for Rehabilitation Services

DSHS – Department of State Health Services

ECI – Early Childhood Intervention

EMR – Employee Misconduct Registry

EMS – Emergency Medical Services

EOB – Explanation of Benefits

EPA – Environmental Protection Agency

ESRD – End Stage Renal Disease

FDA – Food and Drug Administration

FQHC – Federally Qualified Health Centers

HCS – Home and Community-based Services

HHS – Health and Human Services

HHSC – Health and Human Services Commission

HRSA – Health Resources and Services Administration

ICF/IID – Intermediate Care Facilities for Individuals with an Intellectual Disability

ICHP – Institute for Child Health Policy

ICS – Inpatient Consumer Survey

ID – Intellectual Disabilities

IDD – Intellectual or Developmental Disabilities

ILS – Independent Living Services

KHC – Kidney Health Care

LA – Local Authorities

LHD – Local Health Departments

LSDP – Lone Star Delivery and Process

LTSSQR – Long-Term Services and Supports Quality Review

MCO – Managed Care Organization

MHSIP –Mental Health Statistics Improvement Program

MI – Mental Illness

NACES – Nurse Aide Competency Evaluation Service Plus Foundation, Inc.

NAR – Nurse Aide Registry

NATCEP – Nurse Aide Training and Competency Evaluation Program

NCI – National Core Indicators

NF – Nursing Facility

NFQR – Nursing Facility Quality Review

NYTD – National Youth in Transition Database

OIG – Office of Inspector General

OO – HHSC Office of the Ombudsman

OSEP – Office of Special Education Programs

PACE – Program for All-Inclusive Care for the Elderly

PAL – Preparation for Adult Living

PEI – Prevention and Early Intervention

PHSU – Purchased Health Services Unit

PLCU – Regulatory Services Professional Licensing and Certification Unit

PQCU – Patient Quality Care Unit

QMB – Qualified Medicare Beneficiary

SNAP – Supplemental Nutrition Assistance Program

SNF – Skilled Nursing Facility

SSA – Social Security Administration

SSDI – Social Security Disability Insurance

SSI – Supplemental Security Income

SSLC – State Supported Living Centers

STAR – State of Texas Access Reform

TANF – Temporary Assistance for Needy Families

TB – Tuberculosis

TDLR – Texas Department of Licensing and Regulation

TER – Texas Electronic Registrar

THA – Texas Hospital Association

TMA – Texas Medical Association

TMB – Texas Medical Board

TVFC – Texas Vaccines for Children

TxHml – Texas Home Living program

UFSRC – University of Florida Survey Research Center

VR – Vocational Rehabilitation

WIC – Special Supplemental Program for Women, Infants, and Children

YSSF – Youth Services Survey for Families

Schedule H: Health and Human Services System Assessment of Advisory Committees

The materials for the Assessment of Advisory Committees are submitted separately due to large file size. A separate file is available for each of the current five agencies:

- The Health and Human Services Commission,
- The Department of Aging and Disability Services,
- The Department of Assistive and Rehabilitative Services,
- The Department of Family and Protective Services, and
- The Department of State Health Services.

Schedule I: Health and Human Services System Glossary of Acronyms

ACRONYM	FULL NAME
AAA	Area Agency on Aging
ACD	Automatic Call Distributor
ACF	Administration for Children and Families (federal)
ACPAMC	Advisory Committee on Promoting Adoption of Minority Children
ACS	American Community Survey
ADRC	Aging and Disability Resource Center
ADRCAC	Aging and Disability Resource Center Advisory Committee
AHRQ	Agency for Healthcare Research and Quality's (federal)
AIDS	Acquired Immunodeficiency Syndrome
ALF	Assisted Living Facility
AMH	Adult Mental Health
APS	Adult Protective Services
AR	Alternative Response
ASN	Adult Safety Net
ATWAC	Aging Texas Well Advisory Committee
BEI	Board for Evaluation of Interpreters
BEST	Blindness Education, Screening, and Treatment
BET	Business Enterprises of Texas
BHAC	Behavioral Health Advisory Committee
BIAC	Brain Injury Advisory Council
BRFSS	Behavioral Risk Factor Surveillance System
CAHPS	Consumer Assessment of Healthcare Providers and Systems®
CARP	Committee for Advancing Residential Practices
CAS	Community Access and Services
CASA	Court Appointed Special Advocates
CCL	Child Care Licensing
CDC	Centers for Disease Control and Prevention
CEA	Consumer and External Affairs
CEO	Chief Executive Officer
CFCIP	Chafee Foster Care Independence Program
CHIP	Children’s Health Insurance Program
CHW	Community Health Worker

ACRONYM	FULL NAME
CLF	Civilian Labor Force
CMS	Centers for Medicare & Medicaid Services (federal)
CPP	Community Partner Program
CPRIT	Cancer Prevention and Research Institute of Texas
CPS	Child Protective Services
CRCG	Community Resource Coordination Group
CRS	Consumer Rights and Services
CSHCN	Children with Special Health Care Needs
CVD	Cardiovascular Disease
DADS	Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
DCM	Disaster Case Management
DDS	Disability Determination Services
DFPS	Department of Family and Protective Services
DHHS	Department of Health and Human Services (federal)
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
DUR	Drug Utilization Review (Board)
ECI	Early Childhood Intervention
EEO	Equal Employment Opportunity
EMS	Emergency Medical Services
EOB	Explanation of Benefits
EPA	Environmental Protection Agency (federal)
ESP	Emergency Services Program
ESRD	End-Stage Renal Disease
EVI	Electronic Vaccine Inventory
FCISC	Foster Care Improvements Steering Committee
FDA	Food and Drug Administration (federal)
FFY	Federal Fiscal Year
FGPAC	Foster Grandparent Advisory Council
FQHC	Federally Qualified Health Center
FY	Fiscal Year (State)
GAA	General Appropriations Act
GETAC	Governor's EMS and Trauma Advisory Council
GSP	Gross State Product
HAI	Healthcare-Associated Infection

ACRONYM	FULL NAME
H.B.	House Bill
HCID	High-Consequence Infectious Disease
HEART	HHS Enterprise Administrative Report and Tracking
HHS	Health and Human Services (usually HHS System)
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus
HIV MAC	HIV (Human Immunodeficiency Virus) Medication Advisory Committee
HOPES	Healthy Outcomes through Prevention and Early Support
HR	Human Resources
HRSA	Health Resources and Services Administration
HSAC	Healthcare Safety Advisory Committee
HUB	Historically Underutilized Business
ICF/ID	Intermediate Care Facility for Persons with Intellectual Disabilities
ICF/IID	Intermediate Care Facility for Individuals with an Intellectual Disability
ICHP	Institute for Child Health Policy
ID	Intellectual Disability
IDD	Intellectual and Developmental Disabilities
IDDSRAC	Intellectual and Developmental Disability System Redesign Advisory Committee
IDEA	Individuals with Disabilities Education Act (federal)
IG	Inspector General
ILS	Independent Living Services
IT	Information Technology
JCAFS	Joint Committee on Access and Forensic Services
KHC	Kidney Health Care
LBB	Legislative Budget Board
LD	Low Denominator
LHA	Local Health Authority
LHD	Local Health Department
LIDDA	Local Intellectual and Developmental Disability Authority
LSDP	LoneStar Delivery and Process
LVN	Licensed Vocational Nurse
MACRA	Medicare Access and CHIP Reauthorization Act of 2015 (federal)
MCAC	Medical Care Advisory Committee
MCO	Managed Care Organization
MDCP	Medically Dependent Children Program
MHSIP	Mental Health Statistics Improvement Program

ACRONYM	FULL NAME
MI	Mental Illness
MMMTF	Maternal Mortality and Morbidity Task Force
MOU	Memorandum of Understanding
NACES	Nurse Aide Competency Evaluation Service Plus Foundation, Inc.
NBSAC	Newborn Screening Advisory Committee
NCI	National Core Indicators
NF	Nursing Facility
NFAAC	Nursing Facility Administrators Advisory Committee
NYTD	National Youth in Transition Database
OAA	Older Americans Act (federal)
OCA	Office of Consumer Affairs
OIG	Office of Inspector General
OILP	Options for Independent Living Program
OMHC	Office of Mental Health Coordination
ONA	Other Needs Assistance
OO	Office of the Ombudsman
OSEP	Office of Special Education Programs (federal)
OT	Overtime
PAC	Perinatal Advisory Council
PAE	Preventable Adverse Event
PCC	Preparedness Coordinating Council
PCG	Parent Collaboration Group
PCIAC	Palliative Care Interdisciplinary Advisory Council
PCS	Procurement and Contracting Services (HHSC)
PE	Presumptive Eligibility
PEI	Prevention and Early Intervention
PHFPC	Public Health Funding and Policy Committee
PHSU	Purchased Health Services Unit
PLCU	Professional Licensing and Certification Unit
PPP	Public Private Partnership
PQCU	Patient Quality Care Unit
QMP	Quality Monitoring Program
RAC	Preventive Medicine Residency Program—Resident Advisory Committee
RCCL	Residential (Child Care) Licensing
RGSC	Rio Grande State Center
RHP	Regional Healthcare Partnership

ACRONYM	FULL NAME
RMD	Regional Medical Director
RN	Registered Nurse
SAO	State Auditor's Office
S.B.	Senate Bill
SCFRT	State Child Fatality Review Team
SDC	State Data Center
SED	Serious Emotional Disturbance
SILC	State Independent Living Council
SKMCAC	STAR Kids Managed Care Advisory Committee
SMHH	State Mental Health Hospital
SNAP	Supplemental Nutrition Assistance Program
SPHAC	State Preventive Health Advisory Committee
SSA	Social Security Administration (federal)
SSLC	State Supported Living Center
STD	Sexually Transmitted Disease
SWI	Statewide Intake
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TCAD	Texas Council on Alzheimer's Disease and Related Disorders
TCAPDD	Texas Council on Autism and Pervasive Developmental Disorders
TCCD	Texas Council on Consumer Direction
TCCVDS	Texas Council on Cardiovascular Disease and Stroke
TCID	Texas Center for Infectious Disease
TDC	Texas Diabetes Council
TDLR	Texas Department of Licensing and Regulation
TER	Texas Electronic Registrar
THA	Texas Hospital Association
TIERS	Texas Integrated Eligibility and Redesign System
TMA	Texas Medical Association
TMB	Texas Medical Board
TRAB	Texas Radiation Advisory Board
TRAC	Texas Respite Advisory Committee
TSCC	Toxic Substances Coordinating Committee
TSHAC	Texas School Health Advisory Committee
TVFC	Texas Vaccines for Children
TWC	Texas Workforce Commission
TxEVER	Texas Electronic Vital Events Registrar

ACRONYM	FULL NAME
UPL	Upper Payment Limit
U.S.	United States
VR	Vocational Rehabilitation
WCY	Waco Center for Youth
WHS	Women's Health Services
WIC	Special Supplemental Program for Women, Infants, and Children (federal)
YCAC	Youth Camp Advisory Committee
YRBS	Youth Risk Behavior Survey