TEXAS
Health and Human
Services System

Texas DEPARTMENT OF STATE HEALTH SERVICES

# SELF-EVALUATION REPORT

## SUBMITTED TO THE SUNSET COMMISSION

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# I. AGENCY CONTACT INFORMATION

| Department of State Health Services<br>Exhibit 1: Agency Contacts | | | | |
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## II. KEY FUNCTIONS AND PERFORMANCE

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

**Mission**

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

**Objectives**

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

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

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

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

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

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

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

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

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

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

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

**Key Functions**

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

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

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

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

**Prevent and Prepare for Health Threats**

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

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

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

**Build Capacity to Improve Community Health**

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

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

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

**Provide Inpatient Hospitalization Services**

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

**Protect Consumers through Licensing and Regulatory Services**

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

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

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

**Prevent and Prepare for Health Threats**

The prevention and preparedness function contributes to the following objectives.

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

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

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

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

**Build Capacity to Improve Community Health**

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

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

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

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

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

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

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

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

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

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

**Provide Inpatient Hospitalization**

The hospital services function contributes to the following objectives.

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

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

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

**Protect Consumers through Licensing and Regulatory Services**
The consumer protection function ensures timely, accurate licensing, certification, and other registrations; provides standards that uphold safety and consumer protection; and ensures compliance with standards.

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

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

**C. What evidence can your agency provide to show your overall effectiveness and efficiency in meeting your objectives?**

In addition to the Legislative Budget Board (LBB) approved performance measures, DSHS uses various methods to determine how effective and efficient the agency is at meeting its objectives. The information below describes some of those methods.

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

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

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

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

**Complaints Data Monitoring**

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

**Independent Audit Results**

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

**Stakeholder Input**

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

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

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

**Planning Activities**

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

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

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

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

**Priority Initiatives and Operational Improvements**

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

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

**Preparedness Exercises**

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

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

**Health Status Indicators**

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

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

**Accreditation and Certification**

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

**Return on Investment (ROI) and Cost-Effectiveness Studies**

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

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

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

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

**Licenses and Enforcement Actions**

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

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

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

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

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

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

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

**Prevent and Prepare for Health Threats**

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

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

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

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

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

**Build Capacity to Improve Community Health**

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

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

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

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

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

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

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

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

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

**Prevent and Prepare for Health Threats**

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

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

**Build Capacity to Improve Community Health**

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

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

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

**Provide Inpatient Hospitalization**

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

**Protect Consumers through Licensing and Regulatory Services**

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

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

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

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

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

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

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

**Maintaining and Developing the Workforce**

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

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

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

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

**Addressing Infrastructure Needs**

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

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

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

**Enhancing Health Data Quality and Security**

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

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

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

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

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

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

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

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

**Federal Legislation and Regulation**

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

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

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

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

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

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

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

**Litigation**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Enhancing Public Health Response to Disasters and Disease Outbreaks**

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

- Public Health Emergency Preparedness and Response – DSHS coordinates a statewide public and behavioral health preparedness and response program to address the public health and medical response to all hazards, including natural disasters, major accidents, and terrorist acts. DSHS preparedness and response activities rely heavily upon collaborative partnerships with multiple disciplines across a variety of agencies and jurisdictions. DSHS will continue to build local, regional, and state response capabilities and improve plans and procedures for effective response.

- Epidemiological Surveillance Capacity – Epidemiology is essential for the detection, control, and prevention of major health problems, in both emergency and non-emergency situations. Effective preparedness and response depends on case reporting of relevant conditions, injuries, exposures, and diseases; detecting significant health threats such as unusual disease clusters; conducting and documenting investigations of outbreaks and acute environmental exposures; and providing public health recommendations to mitigate adverse effects. DSHS will monitor the retention and recruitment of epidemiologists to ensure the capacity to conduct epidemiological surveillance does not decline significantly due to reductions in federal and state funding streams.

- Outbreak Response – In response to infectious disease outbreaks, DSHS works in partnership with epidemiologists; laboratorians; public health officials; and many local, state, and federal agencies. DSHS staff investigates outbreaks of food-borne, water-borne, respiratory, and vaccine-preventable diseases. Staff works to ensure rapid detection of an outbreak and a coordinated response. DSHS will continue to refine a structured framework within which the agency effectively investigates outbreaks and brings them under control, and, where possible, takes measures to prevent similar outbreaks in the future.

- Food Safety – DSHS estimates that food-borne disease causes approximately 6 million illnesses, 26,000 hospitalizations, and 400 deaths each year in Texas. DSHS has primary responsibility to license and inspect food manufacturers, distributors (including distributors of imported foods), and retailers in Texas; however, not all segments of the food supply chain are adequately regulated. There may be manufacturing, distributing, and/or retail

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

**Preventing Chronic Diseases and Infectious Diseases**

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

- Tobacco Prevention and Control – DSHS used a statewide strategic planning process that included regional and local stakeholders and partners to develop the goals and objectives that guide the Tobacco Prevention and Control Program. Program goals include preventing initiation of tobacco use, increasing cessation of tobacco use by youth and adults, eliminating exposure to secondhand smoke in public places, and eliminating disparities among diverse and special populations. DSHS will continue to provide program activities at the local level through local community coalitions, regional tobacco program coordinators, and Prevention Resource Center tobacco specialists.

- Obesity Prevention – The Nutrition, Physical Activity, and Obesity Prevention (NPAOP) program supports and promotes projects that focus on the CDC's six evidence-based target areas for reducing obesity: increasing physical activity; increasing consumption of fruits and vegetables; decreasing consumption of sugar-sweetened beverages; reducing consumption of high-calorie foods; increasing breastfeeding initiation, duration, and exclusivity; and decreasing television viewing. The program targets large segments of the population by promoting strategies to reduce environmental barriers to healthy living and policies that facilitate healthy choices. With CDC funds, NPAOP supports community projects focusing on evidence-based policy and environmental changes and coordination of subject matter expertise; development of the Strategic Plan for the Prevention of Obesity in Texas; and participation and coordination with state partnerships, councils, and groups to enhance statewide efforts toward obesity prevention. The program also sponsors an obesity summit for statewide partners and online professional training modules for physical activity, sustainable agriculture, and breastfeeding.

- Substance Abuse Prevention – Currently, DSHS funds one statewide prevention training services contract and approximately 193 school- and community-based programs to prevent the use and experimentation of alcohol, tobacco, and other drugs (ATOD) among Texas youth and their families. These programs provide evidence-based curricula and five effective prevention strategies in over 500 school districts across the state. The primary population served is youth, ages 0-17, and the secondary population includes the parents and guardians of these youth. Beginning in fiscal year 2014, these services will target youth, ages 6-18, and the secondary population of parents, grandparents, guardians, and siblings

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

- HIV Prevention and Control – As the number of Texans living with HIV grows, so do the costs of providing treatment and care. The importance of maintaining programs and access to medical care and adherence services continues as a high priority. Supportive services such as case management, medical transportation, and MHSA treatment play key roles in keeping persons with HIV in care and treatment. DSHS will continue to work with communities across Texas to improve the productivity of HIV testing programs by assuring that targeted testing programs focus on groups at highest risk, that providers in health settings in communities of high morbidity establish routine testing, and that public health partner notification programs operate effectively.

- TB Prevention and Control – In 2012, 1,297 cases of TB were reported in Texas, a rate of 4.7 per 100,000 population. TB can strike anyone, but a higher prevalence rate occurs in those born in a foreign country where TB is prevalent, people with diabetes, people with HIV/AIDS, the homeless, and those that work in health care. In order to assure providers promptly identify and report all persons meeting the case definition of suspected or active TB disease, the DSHS prevention and control programs develop and maintain active disease surveillance and promote the use of innovative technologies. Additionally, DSHS programs develop and maintain standard processes to guide outbreak responses and assure that providers identify and screen all persons exposed to TB and, where appropriate, ensure treatment to prevent disease transmission. The programs promote effective treatment modalities that increase compliance among persons diagnosed with latent TB infection and target interventions to populations most at risk for developing TB. In order to assess statewide performance in treating TB, DSHS maintains a robust case management data application.

- Immunizations – Coverage levels for Texas children measured in the National Immunization Survey for 2011 were 74.6 percent. Coverage levels for adults continue to be a challenge. Unlike childhood vaccines that are recommended at specific intervals and ages, the recommendations and licensure for adult vaccines vary over the lifespan. DSHS will continue to support efforts to increase adult immunization rates. To achieve and sustain recent successes, DSHS will continue to promote giving vaccines in the medical home, use the statewide immunization registry, educate providers and the public, and implement reminder/recall systems.

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

**Improving the Health of Infants and Women**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- facilitating and assisting LHDs seeking accreditation through the national Public Health Accreditation Board.

- Capacity and Utilization of Community-based Behavioral Health, Primary Care, and Public Health Services – DSHS will monitor and assess the impact of the changing healthcare environment on the agency, its programs, service providers, and service recipients. As the safety net system experiences shifts in resources and federal and/or state funding priorities, DSHS will make adjustments accordingly. The agency will make efforts to ensure the availability of public health, primary care, and behavioral health services to populations that may not be eligible for coverage through Medicaid, Medicare, or CHIP. Additionally, DSHS will seek to make available evidence-based service delivery approaches that third-party insurance may not cover, but that, when combined with other treatment methodologies, demonstrate improved health status for service recipients.

- Capacity of Inpatient Psychiatric Hospitals – DSHS operates and maintains state-owned facilities, which provide direct services 24 hours per day, seven days per week to individuals requiring inpatient or residential services. These hospitals serve persons who are involuntarily committed through the Texas court system. DSHS is continually challenged to manage the court commitments made across the state within its bed capacity. In recent years, the State Hospital system has experienced the need for increased capacity mainly due to more patients being committed by the courts and patients requiring increased lengths of treatment. The majority of the increase has been for forensic commitments, patients charged with a crime, and suspected of having or found to have a mental illness that requires treatment or restoration of their competency to stand trial. Because the hospital system has admitted an increased number of patients on forensic commitments and because these patients require a longer stay in the hospital, the State Hospital system has experienced an increased use of resources by the forensic population and a corresponding reduction of beds for civilly committed patients.

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

**Meeting Increased Regulatory Demands Due to Business Growth**

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

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

- Risk-Based Approach – Historically, DSHS regulatory programs have prioritized inspections, complaint investigations, and other compliance activities to address issues that are of the highest potential public health risk before other issues. With the rapidly growing number of licenses and resource constraints, the risk-based approach is becoming more critical to assure that DSHS uses resources in an efficient and effective manner. Regulatory efforts must remain protective of public health, while still assuring that licenses are issued in a timely manner to allow individuals and businesses to operate. This will mean that DSHS will no longer investigate some low-risk complaints, refer more complaints to entities for self-investigation, and perform fewer routine inspections.

- Aligning Regulatory Resources to Meet Demands – As directed by the 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, DSHS, Rider 59), DSHS initiated an internal self-evaluation of all regulatory programs and functions to identify opportunities for improving the state's regulatory system. The self-evaluation included examination of:
    - the appropriate level of resources, including staffing, required to perform statutorily required regulatory activities;
    - risk matrices for inspections and complaint investigations timeframes;
    - potential administrative efficiencies and opportunities for programmatic restructuring;
    - potential modifications to regulatory functions aimed at prioritizing activities to those of highest risk for the protection of consumers and public health; and

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

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

**Increasing Emphasis on Healthcare Quality**

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

- Adult Potentially Preventable Hospitalizations (PPH) – Adult Texans experienced approximately 1.4 million PPH from 2006 to 2011. These hospitalizations resulted in approximately $44.3 billion in hospital charges, approximately $2,300 for every adult Texan. To assist communities in addressing this issue, DSHS provides information to state, regional, and local stakeholders on the impact of PPH in their geographical area of interest. The following 10 conditions are classified as PPH, because hospitalization would potentially have not occurred if the individual had access to, and/or cooperated with, outpatient health care: bacterial pneumonia, dehydration, urinary tract infection, angina (without procedures), congestive heart failure, hypertension, asthma, chronic obstructive pulmonary disease, diabetes short-term complications, and diabetes long-term complications. The 82nd Legislature, Regular Session, 2011, appropriated $2 million for DSHS to implement an initiative to reduce PPH in 2012-13 biennium. DSHS successfully executed contracts with 16 counties to target specific PPH conditions. Funded sites are implementing community-coordinated, evidence-based interventions to reduce hospitalizations and/or hospital charges among their adult county residents. In the 2014-15 biennium, DSHS plans to contract with 13 of the 16 counties to continue targeting specific PPH conditions.

- Healthcare-Associated Infection (HAI) Reporting – Approximately 130,000-160,000 infections associated with health care are expected to occur annually in Texas at an estimated cost as high as $2 billion. Senate Bill 288, 80th Legislature, Regular Session, 2007, required DSHS to establish an HAI reporting system. In addition, this legislation charged DSHS with developing and publishing a summary of the infections reported by healthcare facilities, establishing an advisory panel, providing education and training for healthcare facility staff, and providing accurate comparison of HAI data to the public to help individuals make informed decisions about choosing healthcare facilities.

- Preventable Adverse Events (PAEs) Reporting and Patient Safety – Senate Bill 203, 81st Legislature, Regular Session, 2009, requires the reporting of PAEs. CMS has established 10 categories of hospital-acquired conditions (HACs) for which the Medicare program will not provide additional payment to the facility, if the condition was not present on admission.

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

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

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

**Developing Quality Improvement Initiatives for Key Business Processes**

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

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

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

- Return on Investment (ROI) Training: The CDC NPHII staff attended ROI training in Dallas with other Texas CDC NPHII Performance Improvement Managers. Additionally, the Texas Public Health Training Centers provided ROI training for 40 employees using tuberculosis as the example.
- Additional QI Initiatives: Additional efforts include the development of QI webpage for the agency; contract streamlining; development of key performance indicators for the purposes of developing an agency performance measures dashboard; a LHD survey of accreditation readiness and a LHD training toolkit for accreditation; and the development of a health status indicator website.

- Contract Process Improvement Initiative – The goal of the Contract Improvement Initiative is to make the agency's contracting process easier and faster, with a target of at least a 25 percent reduction in the cycle time for contracts and resulting cost savings. The Contract Improvement Initiative enabled a comprehensive mapping of the contracting process. The implementation plan includes the following recommendations, which are being phased in beginning January 2012:
  - proposed adoption of revised contracting process beginning in the fiscal year 2014 contracting period;
  - use of an electronic contracting system and contractor portal that is currently used by another state agency;
  - continuous evaluation of implementation by Internal Audit; and
  - review of opportunities to consolidate functions and duties across the agency, once the system is in place.

- Cost Containment Initiatives – DSHS continues to evaluate opportunities to contain costs. During the 82nd Legislature, Regular Session, 2011, DSHS created residential rehabilitation units as a potential cost containment strategy. DSHS converted 40 acute/sub-acute beds at each of three hospitals (Big Spring State Hospital, Rusk State Hospital, and San Antonio State Hospital) to residential rehabilitation units. Cost savings resulted, because the staffing required for a residential rehabilitation unit is less than is required for an acute/sub-acute unit.

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

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

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

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

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

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## III. HISTORY AND MAJOR EVENTS

**Provide a timeline of your agency's history and key events, including:**

- **the date your agency was established;**
- **the original purpose and responsibilities of your agency;**
- **major changes in responsibilities or statutory authority;**
- **changes to your policymaking body's name or composition;**
- **significant changes in state/federal legislation, mandates, or funding;**
- **significant state/federal litigation that specifically affects your agency's operations; and**
- **key changes in your agency's organization (e.g., a major reorganization of the agency's divisions or program areas).**

**Historical Perspective**

The Legislature established the Department of State Health Services (DSHS) by consolidating of all or part of the following four legacy agencies:

- Texas Department of Health (TDH),
- mental health programs of TDMHMR,
- Texas Commission on Alcohol and Drug Abuse (TCADA), and
- Texas Health Care Information Council (THCIC).

The following history contains major events related to the programs that DSHS delivers today, as well as organizational changes that led up to its creation. Events relating to the establishment of today's Health and Human Services (HHS) System are highlighted in bold.

**1856** The Legislature establishes the first institution in the state for persons with mental illness, located in Austin.

**1879** The Legislature amends the Quarantine Act of 1870 to create the Texas Quarantine Department and to authorize the Governor to appoint a state health officer.

**1903** The Legislature renames the Texas Quarantine Department the Department of Public Health and Vital Statistics.

**1909** The Legislature abolishes the Department of Public Health and Vital Statistics and establishes, in its place, the Texas State Board of Health and expands its public health role significantly to include water safety, mosquito-control programs, dairy and food purity, maternal and child hygiene, venereal and other communicable diseases, and public sanitation. The Board centralizes vital records and expands public health education.

**1919** The Legislature establishes the Texas Board of Control, consolidating the functions of 21 state agencies and charging it with purchasing supplies and overseeing state-run facilities, including state psychiatric hospitals and charitable institutions.

**1927** The Texas State Board of Health becomes the Texas State Department of Health. Services gradually expand to include tuberculosis control, bedding sanitation, cancer control, hospital construction, nursing and convalescent homes, water-pollution control, local health services, and a mental health division.

**1949** The Legislature establishes the Board for Texas State Hospitals and Special Schools and transfers oversight of State Hospitals and schools from the Board of Control.

**1953** The Legislature establishes the Texas Commission on Alcoholism (TCA) to provide for education and study relating to the problems of alcoholism and to promote the establishment of alcohol treatment programs.

**1957** The Texas Mental Health Code becomes law, defining mental illness and setting up procedures for voluntary commitment. The Legislature provides funding for alcoholism counselors in each of the State Hospitals.

**1963** Federal legislation provides grants for the construction of community mental health centers.

**1965** The Legislature abolishes the Board for Texas State Hospitals and consolidates all mental health functions in various agencies into the newly created TDMHMR.

**1970** The first of the public health regions are established in Tyler to deliver a broad range of public health services directly to people in counties and rural areas with no other public health services. Other regions are added over the next several years.

The U.S. Congress enacts the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, which provides federal funds for use in alcohol abuse programs.

**1973** TDMHMR becomes responsible for licensing private mental hospitals.

**1974** The Legislature establishes TDH to replace the Texas State Department of Health. The six-member Texas Board of Health, appointed by the Governor with the advice and consent of the Senate, governs TDH.

*R.A.J. vs. Gilbert* federal lawsuit is filed, alleging that State Hospitals failed to provide adequate treatment in the least restrictive environment possible. Also in 1974, the *Lelsz vs. Kavanagh* federal lawsuit is filed against State Schools (now State Supported Living Centers). This suit is a "right to treatment" suit that alleges that TDMHMR has a responsibility to provide treatment, and not just custodial care, for persons residing in State Schools. These suits result in the improvement of TDMHMR physical facilities, increase staffing ratios, strengthen client rights, and, most importantly, improve treatment to residents and patients of its facilities.

**1981** The 67th Legislature passes S.B. 791, which specifies the State's policy to treat individuals with mental illness and intellectual disabilities in their own communities first.

U.S. Congress funds state block grants for alcohol, drug abuse, and mental health programs. TCA, TDMHMR, and the Texas Department of Community Affairs (TDCA) administer the block grant funds in Texas.

**1985** The Legislature creates TCADA by merging TDCA's Drug Abuse Prevention Division and TCA. The Legislature also requires TCADA and TDMHMR to develop a plan for providing community-based services for people with substance abuse problems to curtail the use of State Hospitals for treatment. TCADA's responsibilities gradually increase to include licensing substance abuse treatment facilities and chemical dependency counselors, establishing substance abuse programs for criminal offenders, treatment of people with substance abuse problems committed by civil courts to community-based programs, and certification of driving while intoxicated, drug, and minors-in-possession offender education programs.

**1987** The Legislature passes S.B. 257, which makes the provision of services to persons with mental illness and intellectual disabilities the responsibility of local agencies and organizations to the greatest extent possible.

**1991** **The Legislature abolishes the Health and Human Services Coordinating Council and creates the Texas Health and Human Services Commission (HHSC), to oversee the state's major health and human services agencies: Texas Department on Aging, Commission for the Blind, Commission for the Deaf and Hearing Impaired, Interagency Council on Early Childhood Intervention, Department of Human Services, Juvenile Probation Commission, Department of Protective and Regulatory Services, Rehabilitation Commission, TCADA, TDMHMR, and TDH. The legislature originally places the Texas Youth Commission under HHSC, but removes it in 1993.**

**1993** TDH is reorganized to assume the following major functions: Family Health Services, Disease Prevention, Environmental and Consumer Health, Special Health Services, Community and Rural Health, and Departmental Administration. In addition, the Legislature transfers all environmental programs to the Texas Water Commission.

**1995** The Legislature passes H.B. 2377, allowing the TDMHMR Board to delegate its authority to designated local MHMR authorities.

The Governor appoints a three-member Conservatorship Board to correct the gross fiscal mismanagement found to exist at TCADA. This is the first case of an agency being placed in conservatorship in the history of the state.

The Legislature creates THCIC to collect data and report on the quality of performance of hospitals and health maintenance organizations (HMOs) operating in Texas.

**1996** Control of TCADA is turned over to a newly appointed five-member Commission.

**1999** The Legislature amends TCADA's disciplinary powers and the requirements governing chemical dependency counseling.

THCIC begins releasing data publicly regarding hospitals and HMOs.

**2003** **House Bill 2292 establishes DSHS by consolidating all or part of four legacy agencies: TDH, the mental health programs of TDMHMR, TCADA, and THCIC. Under the oversight of HHSC, DSHS promotes optimal health for individuals and communities while providing effective health, mental health, and substance abuse services to Texans.**

House Bill 2292 also mandates that the term of licenses, permits, registrations, and certificates issued or renewed by state agencies be two years. This requirement applied to all DSHS regulated programs, except meat safety grants of inspection and youth camp licenses. In addition, this legislation requires DSHS to charge licensing fees in amounts necessary to recover from its license holders all necessary costs to administer and enforce a program.

The Legislature enacts two other bills adding regulatory functions to DSHS. Senate Bill 329 directs DSHS to initiate a new program to regulate mold remediation to ensure that companies and individuals performing regulated mold remediation activities are properly trained and licensed and follow work-practice standards prescribed by DSHS. Senate Bill 599 transfers the responsibility for conducting indoor air quality investigations in state facilities from the Texas Building and Procurement Commission to DSHS.

The Legislature transfers appropriations for Texas Health Steps (THSteps) to HHSC. DSHS continues to conduct day-to-day services for THSteps medical, dental, and case management. In addition, Medicaid family planning funds and performance targets are transferred from DSHS to HHSC.

**2004** **DSHS begins operations on September 1, 2004, and the legacy agencies are abolished. All rulemaking and policymaking authority for the provision of health and human services in Texas transfers to HHSC. The Legislature creates the State Health Services Council to assist the DSHS Commissioner in developing rules and policies for recommendation to the HHSC Executive Commissioner. All powers, duties, functions, programs, and activities related to administrative support services transfer to HHSC.**

DSHS consolidates the management of State Hospitals, Texas Center for Infectious Diseases, and the South Texas Healthcare System under the State Hospitals Section of DSHS.

DSHS undergoes reorganization of its Regulatory Services Division (RSD), creating functional units dedicated to inspections, enforcement, and licensing activities.

HHSC establishes the HHSC Contract Council with responsibility for developing a HHS System common perspective of contract management and implementing a contract management system. HHSC directs all HHS agencies to establish a Contract Oversight and Support Section to provide oversight and ensure accountability for contract management functions.

**2005** Senate Bill 330 requires DSHS, with the assistance of the Governor's Emergency Medical Services and Trauma Advisory Council and its Stroke Committee and in collaboration with the Texas Council on Cardiovascular Disease and Stroke, to develop stroke facility criteria and a statewide stroke emergency transport plan.

DSHS completes the rollout of Resiliency and Disease Management, creating fundamental changes in the type and amount of services delivered to adults with serious mental illness and to children and adolescents with serious emotional disturbance. Two key elements initiated are a uniform assessment and an encounter data reporting and warehousing system.

**2006** DSHS creates the Regional and Local Health Services (RLHS) Division to serve the needs of local public health agencies, DSHS health service regions, and local communities in building and maintaining capacity to provide essential public health services responsive to local needs.

HHSC Office of Inspector General transfers the sub-recipient fiscal auditors to the DSHS Contract Oversight and Support Section to establish a fiscal compliance unit.

**2007** DSHS implements a new leadership structure, creating an associate commissioner position and combining two deputy commissioner positions into a single deputy position to focus on policies, rules, and other integrative activities and initiatives. All HHS Printing Services resources are consolidated under DSHS management.

Senate Bill 1604 transfers the licensing of uranium and low-level waste processing, along with uranium inspections, from the DSHS Division of Regulatory Services to the Texas Commission on Environmental Quality.

The Legislature appropriates $82 million to make significant progress toward improving the response to mental health and substance abuse (MHSA) crises. The first phase of implementation focuses on ensuring statewide access to competent rapid response services, avoiding hospitalization, and reducing the need for transportation. The Legislature continues funding for crisis services redesign for the 2009-10 biennium.

DSHS moves the statewide tobacco prevention and control program from the Prevention and Preparedness Division to the MHSA Services Division, to align better with DSHS efforts to coordinate and streamline programming, allocation of resources, and collaboration with public and private partners through one division.

**2009** DSHS creates the Office of Academic Linkages to enhance and develop opportunities for increased partnerships with academic institutions. The Office brings together the agency's existing activities for continuing education and health professional development with increased efforts to link academia and practice.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) implements an Electronic Benefits Transfer (EBT) food delivery system statewide to replace paper food vouchers. EBT is more convenient for WIC participants and offers a more efficient payment of vendors.

Through exceptional item funding approved by the Legislature, the Newborn Screening Program begins screening for cystic fibrosis, the final disorder recommended for screening by the American College of Medical Genetics, bringing the total to 28.

The Legislature enacts several bills that add regulatory functions to DSHS. House Bill 449 creates a DSHS regulatory program for laser hair removal. The legislation requires licensing of laser hair removal facilities and certification of individuals performing laser hair removal procedures. House Bill 1357 requires DSHS to regulate freestanding emergency medical care facilities. The legislation requires DSHS to license all facilities in accordance with adopted rules by September 1, 2010. House Bill 461 creates the licensing program for dyslexia practitioners and dyslexia therapists, as well as the Dyslexia Licensing Advisory Committee.

**2010** DSHS works with HHSC to implement components of the 2007 *Frew, et al. vs. Suehs, et al.* Agreed Corrective Action Order. The order includes 11 proposals for corrective action. One example is an independent study of the Case Management for Children and Pregnant Women Program conducted through a vendor contracted with HHSC in fiscal year 2009. The study's purpose is to determine ways to outreach to potential clients effectively, to inform healthcare professionals about the program, and to recruit and retain program providers.

DSHS implements a Medicaid benefit for substance abuse. Additionally, substance abuse programs statewide implement the upgraded and more comprehensive electronic record system known as Clinical Management for Behavioral Health Services.

A lawsuit (*Beleno, Andrea, et al. vs. Texas Department of State Health Services, David L. Lakey, M.D., Texas A&M University, Nancy W. Dickey, M.D., and Roderick E. McCallum)* alleges harm because DSHS keeps de-identified bloodspots after screening without parental consent and allows their use in approved quality assurance and research. The parties settle the case in November 2009, with approval of the court, before it ever goes to trial. DSHS meets all the terms of the settlement, including destruction of bloodspots received prior to May 27, 2009, for which there was no written consent to retain and use.

**2011** Senate Bill 166 transfers the functions of the sex offender civil commitment program previously performed by the Council on Sex Offender Treatment at DSHS to the Office of Violent Sex Offender Management (OVSOM), a new entity created by the bill responsible for providing monitoring and treatment of civilly committed sex offenders. DSHS provides administrative support services to OVSOM, including human resources, budgetary, accounting, purchasing, payroll, information technology, and legal support services, as necessary. OVSOM is a state agency subject to the Texas Sunset Act and submits a separate legislative appropriations request.

House Bill 15 requires that a physician provide a pregnant woman a sonogram and a verbal explanation of the image at least 24 hours before an abortion is performed. The bill directs DSHS to develop, maintain, and publish on its public Internet website a list of providers of no-cost sonograms and to receive certification from physicians for exceptions due to medical emergencies.

House Bill 411 requires DSHS to make changes to the newborn screening program. The bill requires approval by the DSHS Commissioner of post-testing release of newborn screening blood spots or data, posting on the public Internet website all approved disclosures, and parental consent for the residual use of blood spots for external public health research purposes. Additionally, the bill requires that all birthing facilities perform a hearing screening on a newborn before discharging the newborn from the facility, and sets guidelines for follow-up care and intervention services, if a newborn does not pass a screening test.

**2012** DSHS transfers the Community Preparedness Section (CPS) to the RLHS Division. Due to this change, the name of the Prevention and Preparedness Services Division, the former location of CPS, is renamed the Disease Control and Prevention Services Division. CPS works closely with other RLHS Division staff to assist with mitigation, preparedness, response and recovery from natural disasters, terrorist attacks, and other public health emergencies.

The Women's Health Laboratory in San Antonio closes effective August 31, 2012.

**2013** On March 3, 2013, the Court relieves defendants, including DSHS, in the *Frew, et al. vs. Janek, et al. (*formerly *Frew, et al. vs. Suehs, et al.*) lawsuit of obligations under the Consent Decree, as well as 1 of the 11 Corrective Action Orders (CAOs), that relate to lagging counties and state wideness requirements. The defendants remain subject to the remaining 10 CAOs and the other requirements of the Consent Decree. None of the CAOs has a specified expiration date, but by their terms, all will start expiring (unless extended by the Court) between 2013 and 2017. The current strategy is to request relief from the Court from each CAO and its corresponding Consent Decree paragraphs as each CAO is completed.

## IV. POLICYMAKING STRUCTURE

**A. Complete the following chart providing information on your policymaking body members.**

| Department of State Health Services<br>Exhibit 3: Policymaking Body | | | |
|---|---|---|---|
| **Member Name** | **Term/Appointment Dates/Appointed by** | **Qualification** | **City** |
| Kyle Janek, M.D., Executive Commissioner, Health and Human Services Commission (HHSC) | Appointed September 1, 2012, by Governor. Term expires February 1, 2015. | Board-certified anesthesiologist and former State Senator and former member of the House of Representatives | Austin |
| **State Health Services (SHS) Council** | | | |
| Glenda R. Kane, Chair | Appointed 2004; reappointed 2009 by Governor.<br>Term expires February 1, 2015. | Public member | Corpus Christi |
| Jeffrey A. Ross, M.D., D.P.M., Vice-Chair | Appointed 2004; reappointed 2007 and 2013 by Governor.<br>Term expires February 1, 2019. | Public member | Bellaire |
| Kirk A. Calhoun, M.D. | Appointed 2008; reappointed 2011 by Governor.<br>Term expires February 1, 2017. | Public member | Tyler |
| Lewis E. Foxhall, M.D. | Appointed 2004; reappointed 2009 by Governor.<br>Term expires February 1, 2015. | Public member | Houston |
| Jacinto P. Juarez, Ph.D. | Appointed 2004; reappointed 2012. New appointment 2013 by Governor.<br>Term expires February 1, 2019. | Public member | Laredo |
| William Lovell | Appointed 2011 by Governor.<br>Term expires February 1, 2017. | Public member | Dallas |
| Nasruddin Rupani | Appointed 2009 by Governor.<br>Term expires February 1, 2015. | Public member | Sugar Land |
| Maria Teran | Appointed 2012; reappointed 2013 by Governor.<br>Term expires February 1, 2019. | Public member | El Paso |

| Department of State Health Services<br>Exhibit 3: Policymaking Body | | | |
|---|---|---|---|
| **Member Name** | **Term/Appointment Dates/Appointed by** | **Qualification** | **City** |
| David Woolweaver, D.D.S. | Appointed 2008; reappointed 2011 by Governor. Term expires February 1, 2017. | Public member | Harlingen |

The Governor appoints the nine SHS Council members with the advice and consent of the Senate. Members serve staggered six-year terms with the terms of three members expiring February 1 of each odd-numbered year. While SHS Council members represent the public, individuals eligible for appointment must have demonstrated an interest in and knowledge of services and problems related to the Department of State Health Services (DSHS).

**B. Describe the primary role and responsibilities of your policymaking body.**

Appointed by the Governor, with the advice and consent of the Senate, the Health and Human Services (HHS) System Executive Commissioner is the rulemaking and policymaking authority for the entire HHS System. The following five HHS System agency councils assist the Executive Commissioner in this system oversight role:

- Health and Human Services Council,
- Aging and Disability Services Council,
- Assistive and Rehabilitative Services Council,
- Family and Protective Services Council, and
- SHS Council.

Statutorily created in Section 1001.021, Texas Health and Safety Code, the SHS Council assists the DSHS Commissioner in developing the agency's rules and policies. The SHS Council studies and makes recommendations to the DSHS Commissioner and the Executive Commissioner regarding agency management and operations, including policies and rules governing client services for persons served or regulated by the agency.

The DSHS Commissioner provides regular briefings to the SHS Council at each quarterly meeting and works with the SHS Council Chair to call subcommittee meetings as appropriate. Such meetings provide an effective forum for public input into the DSHS rules, policies, and budget priorities.

Rules and policies affecting DSHS service delivery and programs originate within the DSHS program area. Once drafted, the DSHS Commissioner vets the change, seeks guidance from the SHS Council, and forwards final recommendations to the HHSC policy advisor for review and final recommendation to the Executive Commissioner. The Executive Commissioner may make changes to the draft policy or rule and ultimately adopts the final product.

**C. How is the chair selected?**

The Governor appoints a member of the Council as the presiding officer (Council Chair) who serves in that capacity at the pleasure of the Governor, as set forth in Section 1001.26, Texas Health and Safety Code. The members of the Council may elect any other identified necessary officers. The SHS Council has elected a vice-chair.

**D. List any special circumstances or unique features about your policymaking body or its responsibilities.**

The HHSC Executive Commissioner is the ultimate rulemaking and policymaking authority for the HHS System. The SHS Council assists DSHS Commissioner in advising the HHSC Executive Commissioner on DSHS rules and policies. This structure – a single Commissioner overseeing a system of five system agencies – is unique in Texas government. Furthermore, the approach of having five standing advisory councils that represent each agency's functions is also unique.

**E. In general, how often does your policymaking body meet? How many times did it meet in FY 2012? In FY 2013?**

By statute, the SHS Council must meet at least quarterly. The SHS Council met four times in fiscal year 2012. Council members also participated in a telephone conference call to review the agency's strategic plan and in a stakeholder meeting to review the agency's fiscal year 2014-2015 legislative appropriations request. In addition, some Council members attended a conference for all HHS System Councils in November 2012.

Although advisory in nature, the SHS Council is subject to the Open Meetings Act, and the presence of a majority of members constitutes a quorum.

**F. What type of training do members of your agency's policymaking body receive?**

SHS Council members receive training before participating as an official Council member. By statute, Section 1001.023, Texas Health and Safety Code, the training program consists of information on:

- enabling legislation for DSHS and the SHS Council;
- agency programs, rules, budget, and audit findings;
- roles and functions of DSHS and the SHS Council, including information regarding its advisory responsibilities;
- divisions of responsibility between the HHSC Executive Commissioner and the DSHS Commissioner; and
- requirements of relevant laws such as Open Meeting, Public Information, Administrative Procedures, Conflict-of-Interest, and applicable ethics policies.

**G. Does your agency have policies that describe the respective roles of the policymaking body and agency staff in running the agency? If so, describe these policies.**

The Legislature created the SHS Council to assist the DSHS Commissioner in developing rules and policies for DSHS, including rules and policies governing the delivery of services and the rights and duties of persons whom DSHS serves or regulates.

Advisory in nature, and unlike boards that oversaw the legacy agencies before consolidation, the SHS Council does not have a direct role in agency operations. To ensure Council members understand this unique role, training covers guiding principles and operating procedures, as well as roles and responsibilities.

Regarding operating procedures, the DSHS Commissioner or designated staff is present at all SHS Council meetings. DSHS staff from the Center for Consumer and External Affairs assists in the meetings and provides administrative support. The DSHS Commissioner sets the meeting agenda after consulting with the Council Chair. DSHS is responsible for posting meeting notices and proposed agendas and providing briefing packets.

**H. What information is regularly presented to your policymaking body to keep them informed of your agency's performance?**

At the regularly scheduled quarterly meetings, and any called meetings, the DSHS Commissioner and senior staff brief the SHS Council to on a variety of subject matters, including the agency's performance, current priorities, and ongoing projects. These briefings can occur as part of the items presented for Council action, or as items strictly for the purpose of informing the Council.

At quarterly meetings in fiscal years 2012 and 2013, the DSHS Commissioner and senior staff frequently presented information on legislative appropriations and actions and special initiatives, such as Healthy Texas Babies, suicide prevention, tuberculosis prevention, West Nile virus response, and community transformation and chronic disease grants.

Additionally, the DSHS Commissioner also sends periodic e-mails to SHS Council members to keep them updated on agency activities.

**I. How does your policymaking body obtain input from the public regarding issues under the jurisdiction of the agency? How is this input incorporated into the operations of your agency?**

Negotiated Rulemaking and Stakeholder Groups. All rulemaking initiatives include a comment period, wherein the agency receives comments on proposed draft rules or rule revisions. Often, as a part of this process, the agency may contact stakeholders to solicit input before the

rules are proposed and the formal public comment period begins. Before implementing a major initiative, staff may conduct stakeholder meetings across the state to gain additional feedback. For example, in Spring 2013, staff from the Family and Community Health Services Division held public meetings before implementing an expansion of the Primary Health Care Program. In addition, the agency formally responds to all comments submitted.

Advisory Committees and Task Forces. A number of advisory committees exist, most statutorily required, to assist in developing policies and rules. A complete listing of all advisory committees is included below.

Open Council Meetings. Seeking public input and stakeholder feedback is a key function for the SHS Council. Ideas presented to the Council better inform members as they make policy recommendations to the DSHS Commissioner and the Executive Commissioner. The guiding principles of the SHS Council include a focus on hearing the concerns and interests of consumers and constituents. To ensure stakeholder input is included in all DSHS Council functions, open public testimony, including written testimony, is a standing agenda item.

**J. If your policymaking body uses subcommittees or advisory committees to carry out its duties, fill in the following chart.**

The SHS Council does not use subcommittees. DSHS has the following advisory committees that provide advice on rules and other matters coming before the SHS Council.

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| **ARTHRITIS ADVISORY COMMITTEE** | **Size:** 11 members<br><br>**Composition:**<br>• Persons with arthritis;<br>• Public health educators or other persons knowledgeable in health education;<br>• Medical experts on arthritis;<br>• Providers of arthritis health care; and<br>• Representatives of national arthritis organizations and their local chapters.<br><br>**Appointed by:** DSHS Commissioner | Statutorily mandated to advise DSHS on planning, implementation, and monitoring of statewide arthritis activities and on increasing health education, public awareness, and community outreach activities related to arthritis. | Texas Health and Safety Code, § 97.007 |
| **BLEEDING DISORDERS ADVISORY COUNCIL** | **Size:** 10 members<br><br>**Composition:**<br>• Physician, nurse, and social worker treating individuals with hemophilia or other bleeding or clotting disorders;<br>• Representative of a federally funded hemophilia treatment center<br>• Representative of a health insurer or health benefit plan;<br>• Representative of a volunteer or nonprofit health organization that serves residents of this state with hemophilia or other bleeding or clotting disorders;<br>• Person who has hemophilia or is a caregiver of a person with hemophilia;<br>• Person with a bleeding disorder | Statutorily mandated to conduct studies and advise DSHS, HHSC, and Department of Insurance on 1) public use data, outcome data, and other related information submitted by or collected by DSHS related to hemophilia or other bleeding or clotting disorders; 2) DSHS disclosure and dissemination of that information; and 3) other issues that affect the health and wellness of persons living with hemophilia or other bleeding or clotting disorders. | Texas Health and Safety Code, § 103A |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | other than hemophilia or caregiver of a person with a bleeding disorder other than hemophilia;<br>• Person with a clotting disorder or caregiver of a person with a clotting disorder; and<br>• Pharmacist who represents a pharmacy provider that is not a specialty pharmacy provider participating in the Drug Pricing Program.<br><br>**Appointed by:** DSHS Commissioner and Department of Insurance Commissioner | | |
| **CHRONIC KIDNEY DISEASE TASK FORCE** | **Size:** 17 members<br><br>**Composition:**<br>• One family practice physician;<br>• One pathologist;<br>• One representative from nephrology department of a state medical school;<br>• One nephrologist in private practice;<br>• Two representatives from different Texas affiliates of the National Kidney Foundation;<br>• One representative from DSHS;<br>• One representative of an insurer that issues a preferred provider benefit plan or of a health maintenance organization;<br>• One representative of clinical laboratories;<br>• One representative of private | Develops a cost-effective plan for prevention, early screening, diagnosis, and management of chronic kidney disease for the state's population; develops a plan for surveillance and data analysis to assess the impact of chronic kidney disease. | Texas Health and Safety Code, Chapter 98 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | renal providers;<br>• One pediatrician in private practice;<br>• One kidney transplant surgeon;<br>• One representative from the Texas Renal Coalition;<br>• Two members of the Senate; and<br>• Two members of the House of Representatives.<br><br>Appointed by: Governor, Lieutenant Governor, and Speaker of the House | | |
| **CODE ENFORCEMENT OFFICERS' ADVISORY COMMITTEE** | **Size:** Seven members<br><br>**Composition:**<br>• Three registered code enforcement officers;<br>• One structural engineer or licensed architect;<br>• Two consumers, one of which must be a certified building official; and<br>• One person involved in the education and training of code enforcement officers.<br><br>**Appointed by:** HHSC Executive Commissioner | Provides professional advice to Code Enforcement Officer regulatory program, including rules. Serves as a forum for stakeholder input; formed at the request of stakeholder groups. | Texas Health and Safety Code, § 11.016<br><br>Rule: Title 25, Texas Administrative Code, § 140.152 |
| **COUNCIL ON ADVISING AND PLANNING FOR THE PREVENTION AND TREATMENT OF MENTAL HEALTH AND** | **Size:** 24 members<br><br>**Composition**:<br>• Seven state agency representatives: HHSC Medicaid, HHSC Social Services, DSHS, Texas Department of Criminal | Reviews and makes recommendations for plans and policies provided by DSHS. Monitors, reviews, and evaluates the allocation and | 42 USC 300x-3<br><br>Rule: Title 25, Texas Administrative Code, § 411.7 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| **SUBSTANCE USE DISORDERS** | Justice, Texas Education Agency, Department of Assistive and Rehabilitative Services, Texas Department of Housing and Community Affairs;<br>• Five family members of persons with mental or substance use disorders;<br>• Six mental health consumers/advocates; and<br>• Six substance use consumers/advocates.<br><br>**Appointed by:** Assistant Commissioner for Mental Health and Substance Abuse Services Division | adequacy of mental health and substance use disorder services. Serves as an advocate for adults and children with mental or substance use disorders. | |
| **DRUG DEMAND REDUCTION ADVISORY COMMITTEE** | **Size:** 30 members<br><br>**Composition**:<br>• Five public members with expertise in reducing drug demand and<br>• One representative from the following agencies: Criminal Justice Division Governor's Office, DFPS, Texas Department of Public Safety, Texas Alcoholic Beverage Commission, DSHS (listed in statute as legacy agencies); Council on Offenders with Mental Impairments, Texas Department of Criminal Justice, Department of Aging and Disability Services, Department of Assistive and Rehabilitative Services, Texas Education Agency, Juvenile Probation | Created by Legislature to provide information for the Governor, Legislature and public about issues relating to reducing drug demand. Charged with creating and coordinating implementation of a drug demand reduction strategy. Submits a report to legislative offices every two years. | Texas Health and Safety Code, § 461.017 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | Commission, Texas Youth Commission, Texas Workforce Commission, Texas Department of Motor Vehicles, Comptroller, and Adjutant General's Department.<br><br>**Appointed by:** DSHS Commissioner – public members; Executive Director or Commissioner of agency – agency members | | |
| **DYSLEXIA LICENSING ADVISORY COMMITTEE** | **Size:** Five members<br><br>**Composition**:<br>• Two dyslexia therapists;<br>• One dyslexia practitioner; and<br>• Two consumer or public members, one of whom must be a person with dyslexia or the parent of a person with dyslexia.<br><br>**Appointed by**: DSHS Commissioner | Provides consultation and advice to DSHS on the dyslexia practitioner and therapist licensing program, training, and certification exam. | Texas Occupations Code, § 403.051<br><br>Rule: Title 25, Texas Administrative Code, § 140.579 |
| **GOVERNOR'S EMERGENCY MEDICAL SERVICES (EMS) AND TRAUMA ADVISORY COUNCIL** | **Size:** 15 members<br><br>**Composition:**<br>• Board-certified emergency physician;<br>• Licensed physician who is an EMS medical director;<br>• Fire chief for a municipality that provides EMS;<br>• Officer or employee of a private EMS provider;<br>• Volunteer who provides EMS;<br>• EMS educator; | Provides professional advice to the EMS regulatory and EMS/Trauma systems programs. Serves as a forum for stakeholder input. Reviews and recommends changes to rules, assesses the need for emergency medical services in the rural areas of the state, and develops a strategic plan for | Texas Health and Safety Code, § 773.012 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | • Member of an EMS air medical team or unit;<br>• Representative of a fire department that provides EMS;<br>• Representative affiliated with a hospital that is a designated trauma facility in an urban community;<br>• Representative affiliated with a hospital that is a designated trauma facility in a rural community;<br>• Representative of a county EMS;<br>• Licensed physician who is a pediatrician with trauma or emergency care expertise;<br>• Trauma surgeon or a registered nurse with trauma expertise; and<br>• Two representatives of the public.<br><br>**Appointed by:** Governor | refining the educational requirements for certification and maintaining certification as emergency medical services personnel. | |
| **HEALTHCARE-ASSOCIATED INFECTIONS (HAI) AND PREVENTABLE ADVERSE EVENTS ADVISORY PANEL** | **Size:** 18 members<br><br>**Composition**:<br>• Four infection control practitioner members;<br>• Three board-certified or board-eligible physician members;<br>• Four additional professionals in quality assessment and performance management;<br>• One officer of a general hospital;<br>• One officer of an ambulatory surgical center;<br>• Three nonvoting members who | Mandated by statute to make recommendations to guide implementation, development, maintenance, and evaluation of HAI reporting system. | Texas Health and Safety Code, Chapter 98 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | are department employees representing DSHS in epidemiology and the licensing of hospitals or ambulatory surgical centers; and<br>• Two members who represent the public as consumers.<br><br>**Appointed by:** DSHS Commissioner | | |
| **HUMAN IMMUNO-DEFICIENCY VIRUS (HIV) MEDICATION ADVISORY COMMITTEE** | **Size:** 11 members<br><br>**Composition**:<br>• Three physicians engaged in treating adults infected with HIV;<br>• One physician actively engaged in treating infants and children infected with HIV;<br>• Four consumers who are diagnosed with HIV;<br>• One administrator of public-nonprofit hospital that provides services to individuals infected with HIV;<br>• One social worker who works with individuals who are infected by HIV; and<br>• One pharmacist who participates in the HIV Medication Program.<br><br>**Appointed by**: HHSC Executive Commissioner | Advises in the development of procedures and guidelines for the Texas HIV Medication Program. Reviews program's goals and aims, evaluates ongoing efforts, recommends short-range and long-range goals and objectives, and recommends medications for addition to or deletion from the program's formulary. | Texas Health and Safety Code, §§ 85.271-85.282<br><br>Rule: Title 25, Texas Administrative Code, § 98.121 |
| **INTERAGENCY OBESITY COUNCIL** | **Size:** Three members<br><br>**Composition**:<br>• DSHS Commissioner; | Monitors and evaluates obesity prevention efforts in the state for both | Texas Health and Safety Code, § 114 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | • Commissioner of Texas Department of Agriculture; and<br>• Commissioner of Texas Education Agency.<br><br>**Appointed by**: Specified in statute | children and adults. | |
| **LOCAL AUTHORITY NETWORK ADVISORY COMMITTEE** | **Size:** Not specified<br><br>**Composition:** Equal numbers of representatives of:<br>• Local mental health authorities;<br>• Community mental health service providers;<br>• Private mental health service providers;<br>• Local government officials;<br>• Advocates and family members of individuals with mental health needs;<br>• Consumers of mental health services; and<br>• Other individuals with expertise.<br><br>**Appointed by**: HHSC Executive Commissioner | Advises the executive commissioner and DSHS commissioner on technical and administrative issues that directly affect local mental health authority responsibilities, evaluation and coordination of initiatives, and development of flexible and responsive contracts. Reviews rules related to local mental health authority operations. | Texas Health and Safety Code, § 533.0351 |
| **MEDICAL RADIOLOGIC TECHNOLOGIST ADVISORY COMMITTEE** | **Size:** 11 members<br><br>**Composition:**<br>• Four consumers;<br>• One licensed physician-radiologist;<br>• One licensed medical physicist or a hospital administrator;<br>• Three certified medical radiologic technologists;<br>• One licensed physician - | Provides professional advice to Medical Radiological Technologist Certification regulatory program, including rules. Serves as a forum for stakeholder input; formed at the request of stakeholder groups. | Texas Health and Safety Code, § 11.016<br><br>Rule: Title 25, Texas Administrative Code, § 140.503 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | radiologic procedures practice, rural community or medically underserved population; and<br>• One registered nurse or certified physician assistant - radiologic procedures practice, rural community or medically underserved population.<br><br>**Appointed by:** HHSC Executive Commissioner | | |
| **NEWBORN SCREENING ADVISORY COMMITTEE** | **Size:** At least 10 members<br><br>**Composition:**<br>• Four physicians, including at least two specializing in neonatal-perinatal medicine;<br>• At least two hospital representatives;<br>• At least two persons who have family members affected by a condition for which newborn screening is or may be required; and<br>• At least two persons who are involved in the delivery of newborn screening services, follow-up, or treatment.<br><br>**Appointed by:** DSHS Commissioner | Established by the 81st Legislature to advise DSHS regarding strategic planning, policy, rules, and services related to newborn screening. Amended by the 82nd Legislature to revise the composition of membership and expand the duties of the committee to include reviewing the necessity of requiring additional screening tests. | Texas Health and Safety Code, § 33.017 |
| **PREPAREDNESS COORDINATING COUNCIL** | **Size:** 21 members<br><br>**Composition:** Representatives from a broad spectrum of key preparedness partners, including:<br>• Three representatives of local health departments or local | Required by both the Centers for Disease Control and Prevention and Office of the Assistant Secretary for Preparedness and Response federal | 42 U.S. C., 247d-3a<br><br>Texas Health and Safety Code, § 11.016 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | governments,<br>• Three representatives from emergency management entities,<br>• Three representatives from community hospitals or other community health providers, and<br>• Three representatives from universities or health science centers.<br><br>**Appointed By:** DSHS Commissioner | cooperative agreements. Provides advice to DSHS and the State Health Services Council on activities regarding preparedness, training, planning, communications, and emergency response. | Rule: Title 25, Texas Administrative Code, § 2.1 |
| **PROMOTOR(A) COMMUNITY HEALTH WORKER TRAINING AND CERTIFICATION ADVISORY COMMITTEE** | **Size:** Nine members<br><br>**Composition:**<br>• Four certified promotores or community health workers;<br>• Two public members;<br>• One member from the Texas Higher Education Coordinating Board, or a higher education faculty member who has teaching experience in community health, public health, or adult education and has trained promotores or community health workers; and<br>• Two professionals who work with promotores or community health workers in a community setting.<br><br>**Appointed by:** DSHS Commissioner | Advises DSHS on rules concerning training and regulation of promotores/ community health workers. | Texas Health and Safety Code, Chapter 48<br><br>Rule:<br>Title 25, Texas Administrative Code, § 146.2 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| **PUBLIC HEALTH FUNDING AND POLICY COMMITTEE** | **Size:** Nine members<br><br>**Composition:**<br>• Local health entity representatives for small, medium, and large municipalities or counties;<br>• Local health entity representative that serves as a local health authority;<br>• Representatives of schools of public health; and<br>• Two public members.<br><br>**Appointed by:** DSHS Commissioner | Defines core public health services a local health entity should provide in a county or municipality; evaluates public health in the state and identifies initiatives for areas that need improvement; identifies funding sources available to local health entities; establishes public health policy priorities; and makes recommendations to DSHS annually. | Texas Health and Safety Code, § 117<br><br>Rule: Title 25, Texas Administrative Code, § 85.2 |
| **REGISTERED SANITARIANS ADVISORY COMMITTEE** | **Size:** Seven members<br><br>**Composition:**<br>• Three registered sanitarians;<br>• One professional engineer or on-site sewage facility professional who is not registered as a sanitarian in Texas;<br>• Two consumers; one of which must be involved in the field of public, consumer, or environmental health services of an industry or occupation which is regulated either by a city or county environmental health unit or department or equivalent, or by DSHS; and<br>• One person who is involved in education in the field of public, | Provides professional advice on regulatory program for sanitarians, including rules, and serves as a forum for stakeholder input. | Texas Health and Safety Code, § 11.016<br><br>Rule: Title 25, Texas Administrative Code, §140.119 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | consumer, or environmental health sciences.<br><br>**Appointed by:** HHSC Executive Commissioner | | |
| **RESPIRATORY CARE PRACTITIONERS ADVISORY COMMITTEE** | **Size:** Nine members<br><br>**Composition:**<br>• Three consumer representatives;<br>• Three physicians with an interest in the practice of respiratory care; and<br>• Three certified respiratory care practitioners.<br><br>**Appointed by:** HHSC Executive Commissioner | Provides professional advice to Respiratory Care Practitioner Certification regulatory program, including rules. Serves as a forum for stakeholder input; formed at the request of stakeholder groups. | Texas Health and Safety Code, § 11.016<br><br>Rule: Title 25, Texas Administrative Code, § 140.203 |
| **STATE PREVENTIVE HEALTH ADVISORY COMMITTEE** | **Size:** Eight members<br><br>**Composition:**<br>• Three consumer representatives and<br>• Five non-consumer representatives (DSHS Commissioner, Block Grant Coordinator, a DSHS regional medical director, a local health official, and a public health school official)<br><br>**Appointed by**: HHSC Executive Commissioner | Required by Federal Preventive Health and Health Services Block Grant application process, works with DSHS in development and implementation of state plan. | 42 U.S.C., § 300w-4<br><br>Rule: Title 25, Texas Administrative Code, § 84.1 |
| **STROKE COMMITTEE (SUBCOMMITTEE OF THE** | **Size:** Seven members<br><br>**Composition:**<br>• Licensed physician eligible for | Assists the Governor's EMS and Trauma Advisory Council in the development of a | Texas Health and Safety Code, § 773.203 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| **GOVERNOR'S EMS AND TRAUMA ADVISORY COUNCIL** | accreditation in vascular neurology;<br>• Licensed interventional neuroradiologist;<br>• Neurosurgeon with stroke expertise;<br>• Member of the Texas Council on Cardiovascular Disease and Stroke who has expertise in stroke care;<br>• Licensed physician recommended by a statewide organization of emergency physicians;<br>• Neuroscience registered nurse with stroke expertise; and<br>• Volunteer member of a nonprofit organization specializing in stroke treatment, prevention, and education.<br><br>**Appointed by:** Governor's EMS and Trauma Advisory Council | statewide stroke emergency transport plan and stroke facility criteria. | |
| **TEXAS COUNCIL ON ALZHEIMER'S DISEASE AND RELATED DISORDERS** | **Size:** 13 members<br><br>**Composition:**<br>• Five public members, one of whom is an individual related to a victim of Alzheimer's disease or related disorders but who is not a primary family caregiver, one of whom is a primary family caregiver, two of whom are members of an Alzheimer's disease and related disorders support group, and one of whom is an interested citizen;<br>• Seven professional members | Advises and recommends needed action for the benefit of persons with Alzheimer's disease and related disorders and their caregivers. Disseminates information on services and related activities. Facilitates coordination of services and activities of state agencies, other service providers, and | Texas Health and Safety Code, Chapter 101<br><br>Rule: Title 25, Texas Administrative Code, Chapter 801 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | with special training and interest in Alzheimer's disease and related disorders, with one representative each from nursing homes, physicians, nurses, public hospitals, private hospitals, home health agencies, and faculty of institutions of higher education; and<br>• Representatives from DSHS and Texas Department of Aging and Disability Services.<br><br>**Appointed by**: Governor, Lieutenant Governor, and Speaker of the House | advocacy groups. Advocates for statewide coordinated research. | |
| **TEXAS COUNCIL ON CARDIO-VASCULAR DISEASE AND STROKE** | **Size:** 11 voting members and 4 non-voting members<br><br>**Composition:**<br>• One licensed physician with a specialization in cardiology;<br>• One licensed physician with a specialization in neurology to treat stroke;<br>• One licensed physician employed in a primary care setting;<br>• One registered nurse with a specialization in quality improvement practices for cardiovascular disease and stroke;<br>• One registered and licensed dietitian;<br>• Two persons with experience and training in public health policy, research, or practice; | Develops a plan to reduce the morbidity, mortality, economic burden of cardiovascular disease and stroke in Texas. Conducts health education, public awareness, and community outreach. Coordinates activities among agencies to improve access to treatment. Develops a database of recommendations for treatment and care. Collects and analyzes information related to cardiovascular disease and stroke. | Texas Health and Safety Code, Chapter 93<br><br>Rule: Title 25, Texas Administrative Code, § 1051.1 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | • Two consumer members, with special consideration given to persons actively participating in the Texas affiliates of the American Heart Association or American Stroke Association, managed care, or hospital or rehabilitation settings; and<br>• Two members from the public that have or care for persons with cardiovascular disease or stroke; and<br>• Nonvoting members representing DSHS, Texas Education Agency, Texas Department of Assistive and Rehabilitative Services; and Texas Department of Aging and Disability Services.<br><br>**Appointed by:** Voting members appointed by Governor, non-voting members appointed by agency commissioners | | |
| **TEXAS DIABETES COUNCIL** | **Size:** 11 members<br><br>**Composition:**<br>• One licensed physician with a specialization in treating diabetes;<br>• One registered nurse with a specialization in diabetes education and training;<br>• One registered and licensed dietitian with a specialization in the diabetes education field;<br>• One person with experience and training in public health policy; | Addresses issues affecting people with diabetes. Advises the Legislature on legislation that is needed to develop and maintain a statewide system of quality education services for all people with diabetes and healthcare professionals who offer diabetes treatment | Texas Health and Safety Code, Chapter 103 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | • Three consumer members, with special consideration given to persons active in the Texas affiliates of the Juvenile Diabetes Foundation or the American Diabetes Association; and<br>• Four members from the public with expertise or demonstrated commitment to diabetes issues.<br><br>**Appointed by:** Governor | and education. | |
| **TEXAS MEDICAL CHILD ABUSE RESOURCE AND EDUCATION SYSTEM (MEDCARES) ADVISORY COMMITTEE** | **Size:** Nine members<br><br>**Composition:**<br>• State Medicaid director or the State Medicaid director's designee;<br>• Medical director for the Texas Department of Family and Protective Services (DFPS) or the medical director's designee;<br>• Two pediatricians with expertise in child abuse or neglect;<br>• One nurse with expertise in child abuse or neglect;<br>• One representative of a pediatric residency training program;<br>• One representative of a children's hospital;<br>• One representative of a children's advocacy center; and<br>• One member of the Governor's EMS and Trauma Advisory Council. | Advises DSHS and the HHSC executive commissioner in establishing rules and priorities for the use of grant funds awarded through MEDCARES program. | Texas Health and Safety Code, § 1001.153 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | **Appointed by:** HHSC Executive Commissioner (except State Medicaid Director and DFPS Medical Director) | | |
| **TEXAS RADIATION ADVISORY BOARD** | **Size:** 18 members<br><br>**Composition:** Representatives of the following areas:<br>• Industry trained in nuclear physics, science, or nuclear engineering;<br>• Labor;<br>• Agriculture;<br>• Insurance industry;<br>• Nuclear physics in medicine;<br>• Hospital administration;<br>• Nuclear medicine;<br>• Pathology;<br>• Radiology;<br>• Nuclear utility industry;<br>• Radioactive waste industry;<br>• Petroleum industry;<br>• Certified health physicists;<br>• Licensed dental examiners;<br>• Uranium mining industry; and<br>• Public.<br><br>**Appointed by:** Governor | Provides technical guidance and advice on radiation programs to DSHS, Texas Commission on Environmental Quality, Railroad Commission of Texas, and Texas Low-Level Radioactive Waste Compact Commission. | Texas Health and Safety Code, §§ 401.015-401.020<br><br>Rule: Title 25, Texas Administrative Code, § 289.130 |
| **TEXAS SCHOOL HEALTH ADVISORY COMMITTEE** | **Size:** 21 members<br><br>**Composition:**<br>• One representative from the Texas Department of Agriculture;<br>• One representative from the Texas Education Agency;<br>• School Health Coordinator from | Assists the DSHS Council in supporting and delivering coordinated school health programs. | Texas Health and Safety Code, § 1001.0711<br><br>Rule: Title 25, Texas Administrative Code, § 37.350 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | DSHS;<br>• One representative from the Governor's Advisory Council on Physical Fitness;<br>• Two individuals representing school superintendents or other school administrators, and/or school district board members;<br>• One registered nurse with school district or school health administrative nursing experience;<br>• Five consumer members who are parents of school-age children with at least one parent of a child with special needs;<br>• One physician, physician assistant, or nurse practitioner providing health services to school-age children;<br>• One representative working in the school setting with certification in student counseling and guidance and/or safety;<br>• Four members representing organizations and/or agencies involved with the health of school children;<br>• One representative working in the school setting with certification as a physical educator;<br>• One representative working in the school setting with certification as a health educator; and<br>• One representative working in | | |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | the school setting as part of the district's school nutrition services.<br><br>**Appointed by:** HHSC Executive Commissioner, delegated to DSHS Commissioner | | |
| **TEXAS STATE PERFUSIONIST ADVISORY COMMITTEE** | **Size:** Five members<br><br>**Composition:**<br>• Two licensed perfusionist members licensed at least three years;<br>• One physician member – certified board of cardiovascular surgery; and<br>• Two members who represent the public.<br><br>**Appointed by:** DSHS Commissioner | Provides professional advice to the perfusionists licensing regulatory program, including rules. Serves as a forum for stakeholder input; established by statute. | Texas Occupations Code, § 603.051<br><br>Rule: Title 25, Texas Administrative Code, § 140.22 |
| **TOXIC SUBSTANCES COORDINATING COMMITTEE** | **Size:** Six members<br><br>**Composition:** Representatives from<br>• DSHS;<br>• Texas Department of Agriculture;<br>• Texas Commission on Environmental Quality;<br>• Texas Parks and Wildlife Department;<br>• Texas Department of Public Safety; and<br>• Railroad Commission of Texas.<br><br>**Appointed by:** Chief | Legislatively mandated to protect and promote the health and environment of Texas through the prevention and control of adverse health and environmental effects related to toxic substances and harmful agents. | Texas Health and Safety Code, §§ 503.002-503.004<br><br>Rule: Title 25, Texas Administrative Code, Chapter 1001 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | administrative officer of the respective agencies | | |
| **WORKSITE WELLNESS ADVISORY COUNCIL** | **Size:** 13 members<br><br>**Composition:**<br>• One representative of the Department of Agriculture;<br>• One representative of the Texas Education Agency;<br>• One representative of the Texas Department of Transportation;<br>• One representative of the Texas Department of Criminal Justice;<br>• Two representatives from DSHS, one that is involved in worksite wellness efforts;<br>• One employee of the Employees Retirement System;<br>• Two state employee representatives of an eligible state employee organization;<br>• One worksite wellness professional;<br>• One representative of the American Cancer Society;<br>• One representative of the American Heart Association; and<br>• One representative of the Texas Medical Association.<br><br>**Appointed by:** HHSC Executive Commissioner | Advises on funding and resource development for worksite wellness programs; identifying food service vendors that successfully market healthy foods; best practices for worksite wellness used by the private sector; and worksite wellness features and architecture for new state buildings based on features and architecture used by the private sector. | Texas Government Code, §§ 664.054-664.059 |
| **YOUTH CAMP ADVISORY COMMITTEE** | **Size:** No more than nine members<br><br>**Composition:**<br>• At least two members of the public and | Required by statute to provide advice on the development of standards, procedures, and rules to implement | Texas Health and Safety Code, § 141.010 |

| Department of State Health Services<br>Exhibit 4: Advisory Committees | | | |
|---|---|---|---|
| **Name of Advisory Committee** | **Size/Composition/ How are members appointed?** | **Description/ Purpose/Duties** | **Legal Basis for Committee** |
| | • Other members who are experienced camping professionals who represent the camping communities of the state.<br><br>**Appointed by:** HHSC Executive Commissioner | the Youth Camp Act. | Rule: 25 Texas Administrative Code, § 265.29 |
| **YOUTH CAMP TRAINING ADVISORY COMMITTEE** | **Size:** Nine members<br><br>**Composition:**<br>• At least two members of the public and<br>• Other members who are experienced camping professionals who represent the camping communities, youth camps, and the Council on Sex Offender Treatment.<br><br>**Appointed by:** DSHS Commissioner | Advise DSHS and HHSC in the development of criteria and guidelines for the training and examination program on sexual abuse and child molestation. | Texas Health and Safety Code, § 141.096<br><br>Rule: 25 Texas Administrative Code, § 265.29 |

## V. FUNDING

**A. Provide a brief description of your agency's funding.**

The Department of State Health Services (DSHS) had an estimated $2.9 billion in the fiscal year 2012 budget. This included 50 percent in General Revenue (GR)-Related Funds, 43 percent in Federal Funds, and 7 percent in Other Funds. DSHS has 41 strategies and 89 sub-strategies. DSHS has about 150 federal funding sources, 25 General Revenue-Dedicated (GR-D) Funds, 9 GR Funds, and 7 Other Funds. Seventy percent of the DSHS GR Fund is for mental health services (community and hospitals), and about eight percent of the GR Fund is for public health. Approximately 1,000 fees support Regulatory Services programs, and an additional 700 fees primarily support Lab Services.

**B. List all riders that significantly impact your agency's budget.**

The 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011, contains 84 riders that affect DSHS. Below is a summary that highlights those that significantly affect the agency's budget.

**Rider 4. Notification of Intent to Use Additional Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant Funds.** DSHS shall notify the Legislative Budget Board (LBB) and the Governor of its intent to use additional federal SAPT block grant funds in excess of the amounts specifically appropriated in the strategies, which total $133,431,971 for fiscal year 2012 and $133,431,971 for fiscal year 2013.

**Rider 8. Transfer of Appropriation – State Owned Hospitals.** DSHS shall transfer from non-Medicaid state appropriated funds the following amounts in each year of the biennium to Health and Human Services Commission (HHSC) for the Disproportionate Share Hospital Reimbursement Program: State Mental Health Hospitals - $290,022,095 and Texas Center for Infectious Disease - $10,410,309. The timing and form of such transfers shall be determined by the Comptroller of Public Accounts in consultation with HHSC.

**Rider 11. Unexpended Construction Balances.** Any unexpended construction, repair, or renovation balances from previous appropriations, estimated to be $13,200,000 from fiscal year 2011 to fiscal year 2012 and included in the method of finance as General Obligation Bond proceeds in Strategy F.1.2., Capital Repair and Renovation: Mental Health Facilities, are appropriated to DSHS for the same purposes.

**Rider 12. Mental Health Appropriation Transfers between Fiscal Years.** DSHS may transfer appropriations made for the fiscal year ending August 31, 2012, to the fiscal year ending August 31, 2013, subject to the certain conditions provided in the Rider and prior approval by the LBB and the Governor.

**Rider 13. Limitation: Transfer Authority.** Authority to transfer funds between any of the DSHS strategies is contingent upon a written notification from DSHS to the LBB and the Governor at least 30 days prior to the transfer, which includes information specified in the rider.

**Rider 14. Laboratory Funding.** All receipts generated by DSHS from laboratory fees during the 2012-13 biennium and deposited in GR-D Account No. 524 under Revenue Object 3561 are appropriated to DSHS for transfer to the Texas Public Finance Authority for the payment of debt services on the project revenue bonds. Appropriations made out of the GR Fund to DSHS in Goal E, Indirect Administration, may be transferred for bond debt service payments only if laboratory fees generated by the laboratory during the biennium are insufficient to support the bond debt service.

**Rider 15. Appropriation Limited to Revenue Collected.** DSHS shall review all of the fee schedules within its authority on an annual basis and provide a copy of the report to the LBB and the Governor no later than January 1 of each year of the biennium. It is the intent of the Legislature that, to the extent feasible, fees, fines, and other miscellaneous revenues as authorized and generated by DSHS cover, at a minimum, the cost of the appropriations made for the programs, as well as the other direct and indirect costs associated with these programs.

**Rider 21. Authorization to Receive, Administer and Disburse Federal Funds.** The appropriations made to DSHS may be used to match Federal Funds granted to the state for the payment of personal services and other necessary expenses in connection with the administration and operation of a state program of health services.

**Rider 24. Appropriation: Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Rebates.** DSHS is authorized to receive and expend WIC rebates and interest earnings associated with WIC rebates for the purposes of the WIC program.

**Rider 29. Unexpended Balances – Preparedness and Prevention and Consumer Protection Services.** All unexpended balances, including GR and All Funds, not otherwise restricted from appropriations to Goal A, Preparedness and Prevention Services, and Goal D, Consumer Protection Services, at the close of the fiscal year ending August 31, 2012, are appropriated for the fiscal year beginning September 1, 2012, only upon prior written approval by the LBB and Governor.

**Rider 30. State Health Program Drug Manufacturer Rebates.** DSHS is authorized to receive and expend drug rebates and interest earnings associated with Kidney Health Care (KHC) drug rebates and Children with Special Health Care Needs (CSHCN) drug rebates for client services for the KHC and CSHCN programs.

**Rider 34. State Owned Multi-Categorical Teaching Hospital Account.** Out of funds appropriated above in Strategy B.3.3., Indigent Healthcare Reimbursement, from the State Owned Multi-categorical Teaching Hospital Account No. 5049, and contingent upon

$11,500,000 being collected and deposited in the Account for the 2012-13 biennium, the amount of $11,500,000 is allocated to DSHS for reimbursement to the University of Texas Medical Branch at Galveston (UTMB) for the provision of healthcare services provided to indigent patients. Any additional unexpended balances on hand in the accounts as of August 31, 2012, are appropriated to the agency for the fiscal year beginning September 1, 2012, for the same purpose, subject to the department notifying the LBB and the Governor in writing at least 30 days prior to budgeting and expending these balances.

**Rider 37. Estimated Appropriation and Unexpended Balance: Permanent Tobacco Funds.** The estimated amounts appropriated out of the Permanent Fund for Children and Public Health, the Permanent Fund for Emergency Medical Services (EMS) and Trauma Care, and the Permanent Hospital Fund for Capital Improvements and the Texas Center for Infectious Disease are out of the available earnings of the funds. Available earnings in excess of the amounts estimated above are appropriated to DSHS.

**Rider 40. Children with Special Health Care Needs.** Amounts appropriated to DSHS in Strategy A.3.4., CSHCN, may only be transferred if such a transfer would not result in a loss of, or reduction in, services or a loss of, or reduction in, persons otherwise eligible for CSHCN services or that results in higher cost projections for the next fiscal biennium. DSHS is directed to maintain provider reimbursement rates for Title V providers that mirror reductions in provider reimbursement rates for Medicaid providers and continue six-month continuous eligibility limitations consistent with the continuous eligibility limitations in effect in the Medicaid program.

**Rider 44. Appropriation: Contingent Revenue.** DSHS is appropriated any additional revenue generated above the amounts identified in the Comptroller of Public Account's Biennial Revenue Estimate for each of the following accounts or revenue objects: Account No. 341, Food and Drug Retail Fees for food and drug inspections; Account No. 524, Public Health Service Fee (excluding any amounts deposited into Revenue Object 3561) for laboratory operations; Revenue Object 3175, Account No. 5017, Asbestos Removal Licensure for asbestos inspections and regulatory activities; Account No. 5021, Certification of Mammography Systems for certification of mammography facilities; Revenue Objects 3616, 3560, and 3562 in the GR Fund for regulating health professionals; Account No. 5024, Food and Drug Registration Fees, for food and drug inspections; Account No. 5022, Oyster Sales, for oyster plant inspections; Revenue Object 3589 in the GR Fund for Radiation Control regulatory activities; Revenue Objects 3123, 3141, 3175, 3555, and 3573 in the GR Fund for environmental regulation; Account No. 19, Vital Statistics, for processing birth and death certificates and other vital records; and Account No. 512, Bureau of Emergency Management, for licensing EMS personnel and providers.

**Rider 46. Texas Online Authority Appropriation.** DSHS is authorized to increase the occupational license, permit, and registration fees imposed on licensees by an amount sufficient to cover the cost of the subscription fee charged by the Texas Online Authority.

**Rider 48. Estimated Appropriations: Perpetual Care Account.** GR-D Perpetual Care Account 8076 funding of $1,765,240 in fiscal year 2012 and $0 in fiscal year 2013 appropriated to Strategy D.1.3., Radiation Control, includes an unexpended balance (estimated to be $1,715,240) from the 2010-11 biennium. Any additional unexpended balance on hand in the account as of August 31, 2011, is appropriated to the agency for the fiscal year beginning September 1, 2011, for the same purpose.

**Rider 49. Unexpended Balances - Community Mental Health Crisis Services.** Any unexpended balances remaining at August 31, 2012, in Strategy B.2.3., Community Mental Health Crisis Services, are appropriated for the same purposes in fiscal year 2013.

**Rider 51. Revolving Account for the Consolidated Health and Human Services Print Shop.** DSHS is expected to establish and maintain the Revolving Account for the Consolidated Health and Human Services Print Shop to account for the expenditures, revenues, and balances of managing a full-cost recovery consolidated print shop. The expenditures, revenues, and balances included for this operation shall be maintained separately by DSHS within its accounting system and funds can only be used for managing the consolidated print shop.

**Rider 53. Pandemic Flu Preparedness.** Using funds appropriated to the agencies, DSHS, in conjunction with the Texas Division of Emergency Management in the Department of Public Safety, shall identify and seek any necessary approvals for federal or other funds available for the purchase of antivirals for pandemic flu preparedness.

**Rider 55. Limitation: Expenditure and transfer of Additional Public Health Medicaid Reimbursements.** In the event that Public Health Medicaid Reimbursement revenues exceed the amounts appropriated, DSHS may spend the Public Health Medicaid Reimbursement funds made available only to the extent authorized in writing by the LBB and the Governor.

**Rider 56. Texas Cancer Registry.** Contingent on the enactment of legislation authorizing the Cancer Prevention and Research Institute of Texas (CPRIT) to issue bonds on an as needed basis, DSHS shall use $2,969,554 in fiscal year 2012 and $2,969,554 in fiscal year 2013 from an Interagency Contract (Other Funds) with CPRIT in Strategy A.1.2., Health Registries, Information, and Vital Records, for maintaining the infrastructure of the cancer registry. In the event the legislation authorizing CPRIT to issue bonds on an as needed basis does not pass, DSHS shall use $2,969,554 in fiscal year 2012 and $2,969,554 in fiscal year 2013 from an Interagency Contract (Other Funds) with the Higher Education Coordinating Board and/or the Health-Related Institutions of Higher Education in Strategy A.1.2., Health Registries, Information, and Vital Records, to maintain the cancer registry.

**Rider 61. Limitation: Reclassification of GR Associated with Maintenance of Effort.** Authority to reclassify DSHS GR associated with Maintenance of Efforts for the Community Mental Health Services, Maternal and Child Health Services, and Substance Abuse Treatment and Prevention block grants is contingent upon submission and approval of a written request to the LBB and the Governor.

**Rider 64. Unexpended Balances: General Obligation Bond Proceeds**. Included in the amounts appropriated in Strategy F.1.2., Repair and Renovation: Mental Health Facilities, are unexpended and unobligated balances of general obligation bond proceeds that have been approved under the provisions of Article IX, Section 17.11 of S.B. 1, 81st Legislature, Regular Session, 2009, remaining as of August 31, 2011, estimated to be $13,200,000. Projects are subject to approval by the LBB prior to issuance of the bond proceeds by the Texas Public Finance Authority. Any unexpended balances in general obligation bond proceeds remaining as of August 31, 2012, are appropriated for the same purposes for the fiscal year beginning September 1, 2012.

**Rider 69. Federally Funded Capital Projects.** DSHS is authorized to transfer from a non-capital budget item to an existing capital budget item or a new capital budget item not present in the agency's bill pattern contingent upon implementation of a new, unanticipated project that is 100 percent federally funded or the unanticipated expansion of an existing project that is 100 percent federally funded. DSHS is required to notify the State Auditor's Office and the Comptroller of Public Accounts and obtain approval from the LBB and Governor.

**Rider 75. Available Earnings from the Permanent Fund for Health and Tobacco Education and Enforcement in Excess of the Biennial Revenue Estimate.** In the event that the Comptroller of Public Accounts estimates that the actual and/or projected revenue of available earnings of the Permanent Fund for Health and Tobacco Education and Enforcement exceeds the amount projected by 2012-13 Biennial Revenue Estimate as eligible for distribution in a fiscal year in the 2012-13 biennium, the additional revenue is appropriated to DSHS for the purposes of supplementing amounts appropriated under Strategy B.2.6., Reduce Use of Tobacco, and supporting programs established under Government Code, §403.105(c).

**Rider 76. Contingency: Expand Physician Trauma Fellowship Slots.** Contingent on passage of legislation to fund the expansion of physician and nursing trauma fellowships by DSHS, $4,500,000 is appropriated in the 2012-13 biennium out of GR-D Account 5111, Designated Trauma Facility and EMS, for this purpose.

**Rider 77. Family Planning Service.** DSHS shall allocate funds appropriated in Strategy B.1.3., Family Planning Services using a methodology that prioritizes distribution and reallocation to first award public entities that provide family planning services, including state, county, local community health clinics, federally qualified health centers, and clinics under the Baylor College of Medicine; secondly, non-public entities that provide comprehensive primary and preventive care as a part of their family planning services; and thirdly, non-public entities that provide family planning services but do not provide comprehensive primary and preventive care.

**Rider 78. Outpatient Competency Restoration Pilot Programs.** Out of the funds appropriated in Strategy B.2.3., Community Mental Health Crisis Services, DSHS shall allocate out of the GR Fund $4,000,000 each year of the biennium to support outpatient competency restoration pilot

programs in Travis, Bexar, Tarrant, and Dallas Counties and the development of five additional pilot programs.

**Rider 79. Funding for Abstinence Sexual Education.** Funds appropriated in Strategy A.3.2., Abstinence Education, including $1,118,417 in the GR Fund, shall be utilized for implementing abstinence sexual education programs to reduce the need for future family planning services for unwed minors.

**Rider 84. Contingency for S.B. 166: Transfer of the Sex Offender Treatment and Supervision Program.** Contingent upon the creation of a state agency to perform the functions relating to the sex offender civil commitment program that are currently performed by the DSHS Council on Sex Offender Treatment (CSOT), the obligations, property, full-time equivalents (FTEs) positions, performance measures, rights, powers, and duties of the CSOT are transferred to the Office of Violent Sex Offender Management. Included in this transfer is $4,037,687 in fiscal year 2012 and $4,766,511 in fiscal year 2013 in Interagency Contract Funds, and 19.5 FTEs in fiscal year 2012 and 23.5 FTEs in fiscal year 2013.

**C. Show your agency's expenditures by strategy.**

| Department of State Health Services<br>Exhibit 5: Expenditures by Strategy — Fiscal Year 2012 (Actual) | | | |
|---|---|---|---|
| **Goal/Strategy** | **Total Amount Spent Aug 2012 MFR** | **Percent of Total Spent** | **Amount of Contract Expenditures Included in Total Amount Spent** |
| A.1.1. Public Health Preparedness and Coordination Services | $86,852,813 | 3.1% | $41,917,438 |
| A.1.2. Registries, Info, & Vital Records | $33,269,812 | 1.2% | $2,447,487 |
| A.2.1. Immunize Children & Adults | $71,105,775 | 2.5% | $19,157,378 |
| A.2.2. HIV/STD Prevention | $181,975,361 | 6.4% | $59,250,964 |
| A.2.3. Infectious Disease Prevention/EPI/Surveillance | $41,862,633 | 1.5% | $23,808,569 |
| A.3.1. Chronic Disease Prevention | $18,508,588 | 0.7% | $11,435,047 |
| A.3.2. Abstinence Education | $7,135,327 | 0.3% | $3,545,581 |
| A.3.3. Kidney Health Care | $21,819,283 | 0.8% | $48,283 |
| A.3.4. Children with Special Needs | $36,835,151 | 1.3% | $2,868,167 |
| A.3.5. Epilepsy Hemophilia Services | $1,262,591 | 0.0% | $936,850 |
| A.4.1. Laboratory Services | $44,177,730 | 1.6% | $0 |

| Department of State Health Services<br>Exhibit 5: Expenditures by Strategy — Fiscal Year 2012 (Actual) | | | |
|---|---|---|---|
| **Goal/Strategy** | **Total Amount Spent Aug 2012 MFR** | **Percent of Total Spent** | **Amount of Contract Expenditures Included in Total Amount Spent** |
| **Subtotal Goal A** | **$544,805,064** | **19.2%** | **$165,415,764** |
| B.1.1. WIC/Farmers Market Nutrition Services | $755,301,635 | 26.6% | $163,886,391 |
| B.1.2. Women & Children's Health | $78,310,359 | 2.8% | $38,393,095 |
| B.1.3. Family Planning Services | $23,935,952 | 0.8% | $9,474,682 |
| B.1.4. Community Primary Care | $14,207,006 | 0.5% | $12,454,573 |
| B.2.1. Mental Health Services – Adults | $292,554,368 | 10.3% | $209,709,204 |
| B.2.2. Mental Health Services – Children | $65,240,300 | 2.3% | $46,766,023 |
| B.2.3. Community Mental Health Crisis Services | $84,294,196 | 3.0% | $72,647,457 |
| B.2.4. NorthSTAR Behavioral Health Waiver | $120,169,145 | 4.2% | $752,047 |
| B.2.5. Substance Abuse Prevention, Intervention, & Treatment | $128,681,553 | 4.5% | $134,098,857 |
| B.2.6. Reduce use of Tobacco Products | $9,889,807 | 0.3% | $6,699,642 |
| B.3.1. EMS & Trauma Care | $68,903,514 | 2.4% | $8,479,490 |
| B.3.3. Indigent Healthcare Services | $5,750,000 | 0.2% | $5,750,000 |
| B.3.4. County Indigent Healthcare Services | $2,201,880 | 0.1% | $0 |
| **Subtotal Goal B** | **$1,649,439,715** | **58.2%** | **$709,111,461** |
| C.1.1. Texas Center for Infectious Disease | $11,751,523 | 0.4% | $0 |
| C.1.2. South Texas Healthcare Systems | $4,577,237 | 0.2% | $0 |
| C.1.3. Mental Health State Hospitals | $401,422,559 | 14.2% | $2,357,120 |
| C.2.1. Mental Health Community Hospitals | $64,403,096 | 2.3% | $64,403,096 |
| **Subtotal Goal C** | **$482,154,415** | **17.0%** | **$66,760,216** |
| D.1.1. Food (Meat) & Drug Safety | $25,775,126 | 0.9% | $853,331 |

| Department of State Health Services<br>Exhibit 5: Expenditures by Strategy — Fiscal Year 2012 (Actual) | | | |
|---|---|---|---|
| **Goal/Strategy** | **Total Amount Spent Aug 2012 MFR** | **Percent of Total Spent** | **Amount of Contract Expenditures Included in Total Amount Spent** |
| D.1.2. Environmental Health | $8,298,569 | 0.3% | $0 |
| D.1.3. Radiation Control | $8,489,791 | 0.3% | $0 |
| D.1.4. Healthcare Professionals | $8,104,115 | 0.3% | $0 |
| D.1.5. Healthcare Facilities | $10,815,682 | 0.4% | $0 |
| D.1.6. Texas.Gov | $1,166,579 | 0.0% | $0 |
| **Subtotal Goal D** | **$62,649,862** | **2.2%** | **$853,331** |
| E.1.1. Central Administration | $19,153,147 | 0.7% | $888,642 |
| E.1.2. IT Program Support | $19,982,034 | 0.7% | $0 |
| E.1.3. Other Support Services | $12,843,905 | 0.5% | $0 |
| E.1.4. Regional Administration | $1,525,544 | 0.1% | $0 |
| **Subtotal Goal E** | **$53,504,630** | **1.9%** | **$888,642** |
| F.1.1. Laboratory Bond Debt | $2,866,609 | 0.1% | $0 |
| F.1.2. Repair & Renovation: Mental Health Facilities | $36,323,666 | 1.3% | $0 |
| **Subtotal Goal F** | **$39,190,275** | **1.4%** | **$0** |
| G.1.1. Office of Violent Sex Offender Management | $4,068,388 | 0.1% | $0 |
| **Subtotal Goal G** | **$4,068,388** | **0.1%** | **$0** |
| **GRAND TOTAL:** | **$2,835,812,349** | **100.0%** | **$943,029,414** |

**D. Show your agency's sources of revenue. Include all local, state, and federal appropriations, all professional and operating fees, and all other sources of revenue collected by the agency, including taxes and fines.**

| Department of State Health Services<br>Exhibit 6: Sources of Revenue — Fiscal Year 2012 (Actual) | |
|---|---|
| **Source** | **Amount** |
| General Revenue (GR) Fund | $635,207,003 |
| GR Match for Medicaid | $51,575,578 |
| GR for Mental Health Block Grant | $243,141,202 |
| GR for Substance Abuse Prevention | $22,436,747 |
| GR for Maternal and Child Health | $40,208,729 |
| GR for HIV Services | $48,575,088 |
| GR Certified as Match for Medicaid | $10,790,940 |
| Insurance Maintenance Tax Fees | $6,841,861 |
| Vendor Drug Rebates – Public Health | $9,577,214 |
| **Subtotal, General Revenue** | **$1,068,354,362** |
| GR-Dedicated (GR-D) – Vital Statistics Account | $4,477,075 |
| GR-D – Hospital Licensing Account | $1,632,148 |
| GR-D – Food and Drug Fee Account | $1,643,629 |
| GR-D – Emergency Management | $2,343,640 |
| GR-D – Public Health Service Fee Account | $13,055,382 |
| GR-D – Commission on State Emergency Communication Account | $1,821,575 |
| GR-D – Asbestos Removal Account | $3,070,628 |
| GR-D – Workplace Chemicals List | $634,998 |
| GR-D – Mammography Systems Account | $1,055,235 |
| GR-D – Oyster Sales Account | $210,484 |
| GR-D – Food and Drug Registration | $5,611,133 |
| GR-D – Animal Friendly | $266,912 |
| GR-D – Tobacco Education/Enforcement | $5,301,335 |
| GR-D – Children and Public Health | $4,867,329 |
| GR-D – EMS and Trauma Care Account | $4,741,250 |
| GR-D – Hospital Capital Improvement | $935,589 |
| GR-D – Teaching Hospital Account | $5,750,000 |
| GR-D – EMS, Trauma Facilities/Care Systems | $2,381,725 |
| GR-D – Trauma Facility and EMS | $59,750,808 |
| GR-D – March of Dimes Plates | $4,953 |
| GR-D –Childhood Immunization | $144,807 |

| Department of State Health Services<br>Exhibit 6: Sources of Revenue — Fiscal Year 2012 (Actual) | |
|---|---|
| **Source** | **Amount** |
| GR-D – Be a Blood Donor Plates | $250 |
| GR-D – Health Department Lab Financing Fees | $2,866,609 |
| GR-D – WIC Rebates | $206,840,000 |
| GR-D – Perpetual Care Account | $0 |
| **Subtotal, General Revenue Dedicated** | **$329,407,494** |
| Federal Funds | $1,182,202,989 |
| **Subtotal, Federal Funds** | **$1,182,202,989** |
| Appropriated Receipts | $50,535,419 |
| Other – Chest Hospital Fees | $2,108,538 |
| Other – DSHS Public Health Medicaid Reimbursement | $62,050,175 |
| Other – Interagency Contracts | $80,591,238 |
| Other – Bond Proceed – General Obligation | $36,169,554 |
| Mental Health Collections – Patient Support and Maintenance | $10,379,037 |
| Mental Health Appropriated Receipts | $14,013,543 |
| **Subtotal, Other Funds** | **$255,847,504** |
| **TOTAL** | **$2,835,812,349** |

**E. If you receive funds from multiple federal programs, show the types of federal funding sources.**

| Department of State Health Services<br>Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual) | | | | | |
|---|---|---|---|---|---|
| **Type of Fund** | **CFDA** | **State/ Federal Match Ratio** | **State Share** | **Federal Share** | **Total Funding** |
| ARRA: Cancer Registry | 93.000.033 | | | $1,120,151 | $1,120,151 |
| ARRA: State Primary Care Offices | 93.414.000 | | | $359,095 | $359,095 |
| ARRA: Immunization Program | 93.712.000 | | | $220,063 | $220,063 |

| Department of State Health Services<br>Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual) | | | | | |
|---|---|---|---|---|---|
| **Type of Fund** | **CFDA** | **State/ Federal Match Ratio** | **State Share** | **Federal Share** | **Total Funding** |
| ARRA: Preventing Healthcare Associated Infections | 93.717.000 | | | $460,153 | $460,153 |
| ARRA: Survey & Cert. Ambulatory | 93.720.000 | | | $95,961 | $95,961 |
| ARRA: Policy/ Environmental Change | 93.723.001 | | | $602,950 | $602,950 |
| ARRA: Mother Friendly Worksite | 93.723.002 | | | $1,372,571 | $1,372,571 |
| ARRA: Tobacco Cessation | 93.723.003 | | | $197,559 | $197,559 |
| ARRA: CPPW Comp IV-BRFSS | 93.724.000 | | | $136,316 | $136,316 |
| ARRA: Enhancing the Interoperability of ImmTRAC | 93.729.000 | | | $9,293 | $9,293 |
| State Food Safety Task Force in Meat & Poultry Processing at Retail | 10.000.000 | | | $329,162 | $329,162 |
| Coop-Agreements with States Intrastate Meat & Poultry Inspection | 10.475.000 | 50% | $5,079,865 | $5,079,865 | $10,159,730 |
| Field Automation & Info. Management | 10.475.001 | | | $7,885 | $7,885 |
| Intrastate Meat & Poultry Inspection - Technical Assistance Overtime | 10.475.002 | | | $63,424 | $63,424 |
| School Breakfast Program | 10.553.000 | | | $161,204 | $161,204 |
| National School Lunch Program | 10.555.000 | | | $247,784 | $247,784 |

| Department of State Health Services<br>Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual) | | | | | |
|---|---|---|---|---|---|
| **Type of Fund** | **CFDA** | **State/ Federal Match Ratio** | **State Share** | **Federal Share** | **Total Funding** |
| Supplemental Nutrition Program (WIC) | 10.557.001 | | | $513,548,490 | $513,548,490 |
| WIC Breastfeeding Peer Counseling | 10.557.013 | | | $11,680,532 | $11,680,532 |
| Child & Adult Care Food Program | 10.558.000 | | | $49,189 | $49,189 |
| Summer Food Service Program - Children | 10.559.000 | | | $4,554 | $4,554 |
| WIC Farmers Market Nutrition Program | 10.572.000 | | | $13,790 | $13,790 |
| National School Lunch Program Equipment Assistance | 10.579.000 | | | $1,067,391 | $1,067,391 |
| Bureau of the Census | 11.000.000 | | | $4,403 | $4,403 |
| Housing Opportunities -AIDS | 14.241.000 | | | $3,010,055 | $3,010,055 |
| Car Seat & Occupant Project | 20.600.002 | | | $1,063,759 | $1,063,759 |
| Vital Statistics OPM Birth Verifications | 27.000.000 | | | $118,783 | $118,783 |
| Air Pollution Control Program Support | 66.001.000 | MOE | $360,530 | $506,640 | $867,170 |
| State Indoor Radon Grants | 66.032.000 | 40% | $43,362 | $65,043 | $108,405 |
| Enhancing Rad. Lab Capability | 66.034.000 | | | $176,043 | $176,043 |
| Texas PCB/Asbestos in Schools | 66.701.002 | 25% | $46,792 | $140,376 | $187,168 |
| TSCA Title IV State Lead Grants | 66.707.000 | | | $337,991 | $337,991 |

| Department of State Health Services<br>Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual) | | | | | |
|---|---|---|---|---|---|
| **Type of Fund** | **CFDA** | **State/ Federal Match Ratio** | **State Share** | **Federal Share** | **Total Funding** |
| Transport of Transuranic Wastes to the Waste Isolation Pilot Plant | 81.106.000 | | | $201,805 | $201,805 |
| State Energy Program Special Projects | 81.119.000 | | | $266,311 | $266,311 |
| Vital Statistics CSPC Death Certificates | 87.000.000 | | | $13,551 | $13,551 |
| National Death Index | 93.000.000 | | | $1,065,348 | $1,065,348 |
| Vital Statistics Coop Program | 93.000.004 | | | $1,162,505 | $1,162,505 |
| FDA Food Inspections | 93.000.005 | | | $924,886 | $924,886 |
| National Death Index | 93.000.009 | | | $77,286 | $77,286 |
| Tissue Residue Inspection | 93.000.010 | | | $70,404 | $70,404 |
| Vital Statistics Maternal Mortality | 93.000.030 | | | $12,916 | $12,916 |
| Strengthening Public Health Services | 93.018.000 | | | $1,158,982 | $1,158,982 |
| Improving Public Health Laboratory Infrastructure | 93.065.000 | | | $1,348 | $1,348 |
| Public Health Bioterrorism | 93.069.000 | 10% | $4,202,824 | $37,825,416 | $42,028,240 |
| Envir. Public Health & Emer. Resp: TX Asthma Control | 93.070.000 | | | $579,070 | $579,070 |
| Food & Drug Administration | 93.103.000 | | | $948,802 | $948,802 |
| State Systems Development Initiative | 93.110.005 | | | $104,508 | $104,508 |

| Department of State Health Services<br>Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual) | | | | | |
|---|---|---|---|---|---|
| **Type of Fund** | **CFDA** | **State/ Federal Match Ratio** | **State Share** | **Federal Share** | **Total Funding** |
| Project & Coop Agreements: TB | 93.116.000 | | | $6,671,410 | $6,671,410 |
| Tuberculosis Epidemiologic Studies | 93.116.001 | | | $413,506 | $413,506 |
| Primary Care Services Res. | 93.130.000 | | | $353,034 | $353,034 |
| Rape Prevention & Education | 93.136.003 | | | $3,561,045 | $3,561,045 |
| Projects for Assistance | 93.150.000 | 33% | $2,202,894 | $4,472,543 | $6,675,437 |
| Hansen's Disease National | 93.215.000 | | | $515,972 | $515,972 |
| Family Planning Services | 93.217.000 | | | $16,089,094 | $16,089,094 |
| Mental Health Data Infrastructure | 93.230.003 | | | $132,944 | $132,944 |
| Abstinence Education | 93.235.000 | 8.5% | $541,508 | $6,678,594 | $7,220,102 |
| State Capacity Building | 93.240.000 | | | $712,250 | $712,250 |
| Project Reg. & National Significance | 93.243.000 | 10% | $293,441 | $2,640,967 | $2,934,408 |
| Universal Newborn Hearing, Screening, & Intervention | 93.251.000 | | | $351,978 | $351,978 |
| Texas Occupational Health Surveillance | 93.262.000 | | | $161,502 | $161,502 |
| Immunization Grant | 93.268.000 | | | $23,158,595 | $23,158,595 |
| State Based Oral Health Disease Prevention | 93.283.000 | | | $257,619 | $257,619 |
| Chronic Disease Prevention | 93.283.001 | 25% | $157,471 | $472,412 | $629,883 |

| Department of State Health Services<br>Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual) | | | | | |
|---|---|---|---|---|---|
| **Type of Fund** | **CFDA** | **State/ Federal Match Ratio** | **State Share** | **Federal Share** | **Total Funding** |
| Elevated Blood Lead Level | 93.283.003 | | | $30,365 | $30,365 |
| Tobacco Use Prevention | 93.283.007 | 25% | $642,620 | $1,927,860 | $2,570,480 |
| Capacity Building Analysis | 93.283.008 | | | $675,949 | $675,949 |
| State Epidemiology & Lab | 93.283.011 | | | $1,962,583 | $1,962,583 |
| Centers Prevent Birth Defects | 93.283.013 | | | $1,480,329 | $1,480,329 |
| National Program of Cancer Registries | 93.283.014 | 33% | $1,028,180 | $2,087,516 | $3,115,696 |
| Pregnancy Risk Monitoring | 93.283.019 | | | $141,170 | $141,170 |
| Asthma - Public Health Perspective | 93.283.020 | | | $428,387 | $428,387 |
| Support Oral Disease Prevention | 93.283.021 | | | $13,701 | $13,701 |
| National Breast & Cervical Cancer | 93.283.022 | 33% | $3,266,561 | $6,632,109 | $9,898,670 |
| Comprehensive Cancer Control | 93.283.023 | 10% | $60,344 | $543,100 | $603,444 |
| Viral Hepatitis Coord. Project | 93.283.027 | | | $74,468 | $74,468 |
| Texas Early Hearing Detection Interv. | 93.283.028 | | | $304,960 | $304,960 |
| Food Safety & Security Monitoring Project | 93.448.000 | | | $453,918 | $453,918 |
| Public Health Infrastructure, Component I | 93.507.000 | | | $760,642 | $760,642 |
| ACA: CDC - Communities Putting Prevention to Work | 93.520.000 | | | $399,371 | $399,371 |

| Department of State Health Services<br>Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual) | | | | | |
|---|---|---|---|---|---|
| **Type of Fund** | **CFDA** | **State/ Federal Match Ratio** | **State Share** | **Federal Share** | **Total Funding** |
| Epidemiology, Laboratory & Health Information Systems Capacities | 93.521.000 | | | $1,229,475 | $1,229,475 |
| Enhanced HIV Prevention Planning | 93.523.000 | | | $1,493,829 | $1,493,829 |
| ACA: Community Transformation grant | 93.531.000 | | | $8,984,661 | $8,984,661 |
| ACA: Childhood Obesity Research Demo | 93.535.000 | | | $133,953 | $133,953 |
| ACA: HCR P&P Health Fund | 93.539.000 | | | $62,134 | $62,134 |
| ACA: Collaborative Chronic Disease | 93.544.000 | | | $1,405,038 | $1,405,038 |
| TANF to Title XX | 93.558.667 | | | $22,301,379 | $22,301,379 |
| Refugee & Entrant Assistance | 93.566.000 | | | $6,166,258 | $6,166,258 |
| Refugee & Entrant | 93.576.000 | | | $152,036 | $152,036 |
| Social Services Block Grants | 93.667.000 | | | $12,851,395 | $12,851,395 |
| Clinical Lab Amend Program | 93.777.003 | | | $1,356,192 | $1,356,192 |
| Health Insurance Benefits | 93.777.005 | | | $3,718,940 | $3,718,940 |
| Medical Assistance Program | 93.778.000 | various | $62,366,518 | $118,732,989 | $181,099,507 |
| Money Follows the Person-Federal | 93.779.000 | | | $3,378,699 | $3,378,699 |
| Bioterrorism Hospital Preparedness | 93.889.000 | 10% | $3,064,070 | $27,576,629 | $30,640,699 |
| HIV Care Formula Grants | 93.917.000 | MOE | $48,575,088 | $76,791,986 | $125,367,074 |

| Department of State Health Services<br>Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual) | | | | | |
|---|---|---|---|---|---|
| **Type of Fund** | **CFDA** | **State/ Federal Match Ratio** | **State Share** | **Federal Share** | **Total Funding** |
| HIV Prevention Activities | 93.940.000 | | | $17,864,959 | $17,864,959 |
| HIV | 93.944.000 | | | $3,171,602 | $3,171,602 |
| Morbidity & Risk Behavior Survey. | 93.944.002 | | | $555,921 | $555,921 |
| Assistance Program For Chronic Disease Prevention & Control | 93.945.000 | | | $316,777 | $316,777 |
| Pregnancy Risk Assessment | 93.946.019 | | | $3,014 | $3,014 |
| Block Grants for Mental Health | 93.958.000 | MOE | $243,141,202 | $36,020,727 | $279,161,929 |
| Block Grants for Substance Abuse Prevention | 93.959.000 | MOE | $22,436,747 | $118,670,050 | $141,106,797 |
| Comprehensive STD Prevention Systems | 93.977.000 | | | $7,015,862 | $7,015,862 |
| Mental Health Disaster Assistance & Emergency Mental Health | 93.982.000 | | | $385,271 | $385,271 |
| Diabetes Control Programs | 93.988.000 | | | $1,014,855 | $1,014,855 |
| Preventive Health & Health Services | 93.991.000 | MOE | $12,824,638 | $2,587,688 | $15,412,326 |
| Maternal & Child Health | 93.994.000 | MOE | $40,208,728 | $32,215,368 | $72,424,096 |
| Maintain Vital Records | 96.000.000 | | | $48,786 | $48,786 |
| Enumeration at Birth | 96.000.001 | | | $977,172 | $977,172 |
| Death Records - State of Texas | 96.000.002 | | | $283,391 | $283,391 |
| Vital Statistics SSA Birth Verifications | 96.000.003 | | | $5,368 | $5,368 |

| Department of State Health Services<br>Exhibit 7: Federal Funds — Fiscal Year 2012 (Actual) | | | | | |
|---|---|---|---|---|---|
| **Type of Fund** | **CFDA** | **State/ Federal Match Ratio** | **State Share** | **Federal Share** | **Total Funding** |
| Crisis Counseling | 97.032.000 | | | $209,379 | $209,379 |
| Public Assistance Grants | 97.036.000 | | | $3,297,700 | $3,297,700 |
| **GRAND TOTAL** | | | **450,543,383** | **1,182,202,989** | **1,632,746,372** |

**F. If applicable, provide detailed information on fees collected by your agency.**

| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| Abusable Volatile Chemical Permit, Health & Safety Code 485.012 & .013 | $55 | 11,285 | $634,738 | General Revenue |
| Bedding Fees, Health & Safety Code 345.043 | $55 - $1,320 plus .03 for each article over $100,000 | 2,534 | $907,948 | General Revenue |
| Food Service Worker, Health & Safety Code 438.047 | $10 - $600 | 1,206 | $38,066 | General Revenue |
| Asbestos Removal Licensure, Occupations Code 1954.056, .105, .108, .109, .201, .203 & .204 | $25 - $3,210 | 4,561 | $4,272,445 | General Revenue-Dedicated |
| Athletic Trainers, Occupations Code 451.106 & .201 - .203 | $60 - $250 | 1,880 | $426,076 | General Revenue |

| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| Code Enforcement Officers, Occupations Code 1952.052 & .102 – .105 | $50 - $100 | 1,238 | $161,582 | General Revenue |
| Mold Assessors/ Remediators, Occupations Code 1958.055 | $25- $1,000 | 2,714 | $593,919 | General Revenue |
| Training of Counselors, Health & Safety Code 85.087 | $300 | 0 | 0 | General Revenue |
| Lead-Based Paint Certification Program, Occupations Code 1955.053, .055 & .057-.058 | $50-$2,000 | 633 | $241,930 | General Revenue |
| Narcotic Treatment Programs, Health & Safety Code 466.023 | $100 - $1,000 and $60 per patient | 80 | $372,220 | General Revenue |
| Special Care Facilities, Health & Safety Code 248.022 & .024 | $600 - $5,000 | 4 | $1,340 | General Revenue |
| Tanning Facility Fees, Health & Safety Code 12.0111 & 145.010 | $220 - $440 | 858 | $400,436 | General Revenue |
| Body Piercing, Health & Safety Code 12.0111 & 146.005 | $150 - $400 | 510 | $182,629 | General Revenue |
| Tattoo Studios, Health & Safety Code 12.0111 & 146.005 | $450 - $900 | 781 | $719,259 | General Revenue |

| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| School Cafeteria and Non Profit Inspections, Health & Safety Code 437.0125 | $300 | 1,167 | $381,246 | General Revenue |
| Render's Licensing, Health & Safety Code 12.0111 & 144.072 - .073 | $50 - $3,000 | 588 | $143,917 | General Revenue |
| Milk Industry Products, Health & Safety Code 12.0111 & 435.009 | $200 - $800; $0.045 per 100 lbs. of milk | 874 | $2,306,071 | General Revenue |
| Meat Inspection, Health & Safety Code 433.009 | $29.50 per hour per program employee | 1,150 | $37,330 | General Revenue |
| Oyster Sales, Health & Safety Code 436.103 | $1.00 per barrel; $5 per container exceeding 110 lbs. | 66 | $198,999 | General Revenue-Dedicated |
| Bottled or Vended Water, Health & Safety Code 12.0111 & 441.002 | $50 - $100 | 314 | $37,773 | General Revenue |
| Food, Drug, Device & Cosmetic Salvage, Health & Safety Code 12.0111 & 432.009-.010 | $600 - $1,200 | 79 | $130,098 | General Revenue |

| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| Food and Drug Wholesale Distribution/ Manufacturing, Health & Safety Code 12.0111, 431.204, .222, .224, .241 & .409 | $5.00 - $2,295 | 17,539 | $7,640,697 | General Revenue-Dedicated |
| Food Service Establishments, Health & Safety Code 12.0111 & 437.0125 | $50 - $750 | 5,831 | $2,562,635 | General Revenue-Dedicated |
| Frozen Desserts, Health & Safety Code 12.0111 & 440.013 | $800 and 0.015 per 100 lbs. | 38 | $371,506 | General Revenue |
| Medical Device Distributor and Manufacturer, Health & Safety Code 12.0111 & 431.276 | $200 - $3,600 | 803 | $770,856 | General Revenue |
| Pseudoephedrine Certificate of Authority, Health & Safety Code 486.004 | $600 | 18 | $10,200 | General Revenue |
| Hazardous Products Manufacturing, Health & Safety Code 12.0111, 501.024 & 501.026 | $630 | 676 | $452,476 | General Revenue |
| Abortion Facilities, Health & Safety Code 245.005 & .007 | $5,000 | 18 | $134,563 | General Revenue |

| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| Ambulatory Surgical Centers, Health & Safety Code 243.005 & .007 | $5,200 | 218 | $1,168,560 | General Revenue |
| Birthing Centers, Health & Safety Code 244.005 & .007 | $2,000 | 30 | $58,480 | General Revenue |
| Chemical Dependency Treatment Facilities, Health & Safety Code 464.007 | $35 - $1,200 | 273 | $205,845 | General Revenue |
| End Stage Renal Disease, Health & Safety Code 251.002 & .013 | $3,500 - $6,700 | 286 | $1,393,580 | General Revenue |
| Freestanding Emergency Room, Health & Safety Code 254.053 & 254.102 | $3,035 - $14,820 | 38 | $620,593 | General Revenue |
| Hospital Licensing, Health & Safety Code 241.022 & 0.25 | $39 per bed | 418 | $2,717,268 | General Revenue-Dedicated |
| Private Psychiatric Hospitals & Crisis Stabilization Units (Private Mental Hospital), Health & Safety Code 577.004 & .006 | $200 per bed, minimum $6,000 | 29 | $256,963 | General Revenue |

| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| Mammography Systems Certification and Accreditation, Health & Safety Code 401.427 | $240 - $2,010 | 679 | $1,240,218 | General Revenue-Dedicated |
| Emergency Medical Services, Health & Safety Code 773.050, .052, .054-.0572, .059-060, .0611, .071, .116 & .147 | $10 - $5,000 | 18,172 | $2,504,886 | General Revenue-Dedicated |
| Medical Radiologic Technologist Certification, Occupations Code 601.057 | $20 - $1,000 | 16,502 | $1,057,565 | General Revenue |
| Midwifery Training, Occupations Code 203.152, .253 | $35 - $550 | 102 | $54,734 | General Revenue |
| Perfusionists Licensing, Occupations Code 603.154, .252, .253, .255, .259, .301 & .303 | $75 - $350 | 216 | $64,419 | General Revenue |
| Respiratory Care Practitioners, Occupations Code 604.053 | $20 - $120 | 7,961 | $811,238 | General Revenue |
| Licensed Chemical Dependency Counselors, Occupations Code 504.053 | $25 - $115 | 3,714 | $375,220 | General Revenue |

| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| Offender Education Programs, Various Codes, Alcohol Beverage Code 106.115(a)(2); Health & Safety Code 461.012(a)(18); Transportation Code 521.376(3); Code of Criminal Procedures, 42.12 | $5 - $300 | 1,337 | $113,438 | General Revenue |
| Dietitians, Occupations Code 701.154, .252, .259, .2575, .260 & .301 - .302 | $20 - $300 | 2,675 | $259,405 | General Revenue |
| Food Manager Certification, Health & Safety Code 12.0111 & 438.106 | $10 - $2,000 | 4 | $8,539 | General Revenue |
| Hearing Aid Dispensers, Occupations Code 402.106, .203, .207, .251 & .301 | $205 - $500 | 558 | $193,202 | General Revenue |
| Marriage and Family Therapists, Occupations Code 502.152-53, .254 & .257 | $10 - $130 | 1,825 | $262,467 | General Revenue |
| Massage Therapists, Occupations Code 455.153 & .160- .161 | $20 - $2,800 | 15,928 | $2,150,243 | General Revenue |

| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| Medical Physicists, Occupations Code 602.151, .203, .210 & .213 | $20 - $250 | 381 | $89,894 | General Revenue |
| Dispensing Opticians/Contact Lens Dispensers, Occupations Code 352.054, .102 & 353.055 - .056 | $20 - $600 | 131 | $35,081 | General Revenue |
| Personal Emergency Response System, Health & Safety Code 12.0111 & 466.023 (e)-(g) | $20 - $800 | 160 | $48,200 | General Revenue |
| Professional Counselors, Occupations Code 503.202, .310, .354 & .355 | $30 - $150 | 11,556 | $1,291,528 | General Revenue |
| Prosthetics and Orthotics, Occupations Code 605.152, .254, .255, & .259 | $25 - $500 | 434 | $160,719 | General Revenue |
| Sanitarian Registration, Occupations Code 1953.052, .104-106, & .151 | $50 - $150 | 720 | $80,029 | General Revenue |
| Dyslexia, Occupations Code 403.102 | $20 - $280 | 466 | $72,454 | General Revenue |

| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| Speech Pathologists and Audiologists, Occupations Code 401.204, .302, .303, .305, .307, .310, .352 & .353 | $45 - $150 | 9,274 | $1,072,718 | General Revenue |
| Bloodborne Pathogen Control, Health & Safety Code 81.307 | $1,000 - $1,500 | 0 | 0 | General Revenue |
| Youth Camp Inspection, Health & Safety Code 141.0035, .004, .005 & .0095 | $50 - $750 | 505 | $165,598 | General Revenue |
| Workplace (Tier II) Chemical Lists, Health & Safety Code 505.006 & .016, 506.006 & .017, & 507.006 & .013 | $50 - $500 | 63,326 | $1,023,566 | General Revenue-Dedicated |
| Vital Statistics, Health & Safety Code 191.0045, 192.0021, 193.001 & 194.005 | $3 - $60 | 433,021 | $14,335,644 | General Revenue-Dedicated |
| Laser Hair Removal Certified Technicians, Health & Safety Code 401.301 & .512 | $50 - $150 | 1,395 | $146,562 | General Revenue |
| Laser Hair Removal Facility, Health & Safety Code 401.301 | $253 - $1,260 | 181 | $123,564 | General Revenue |

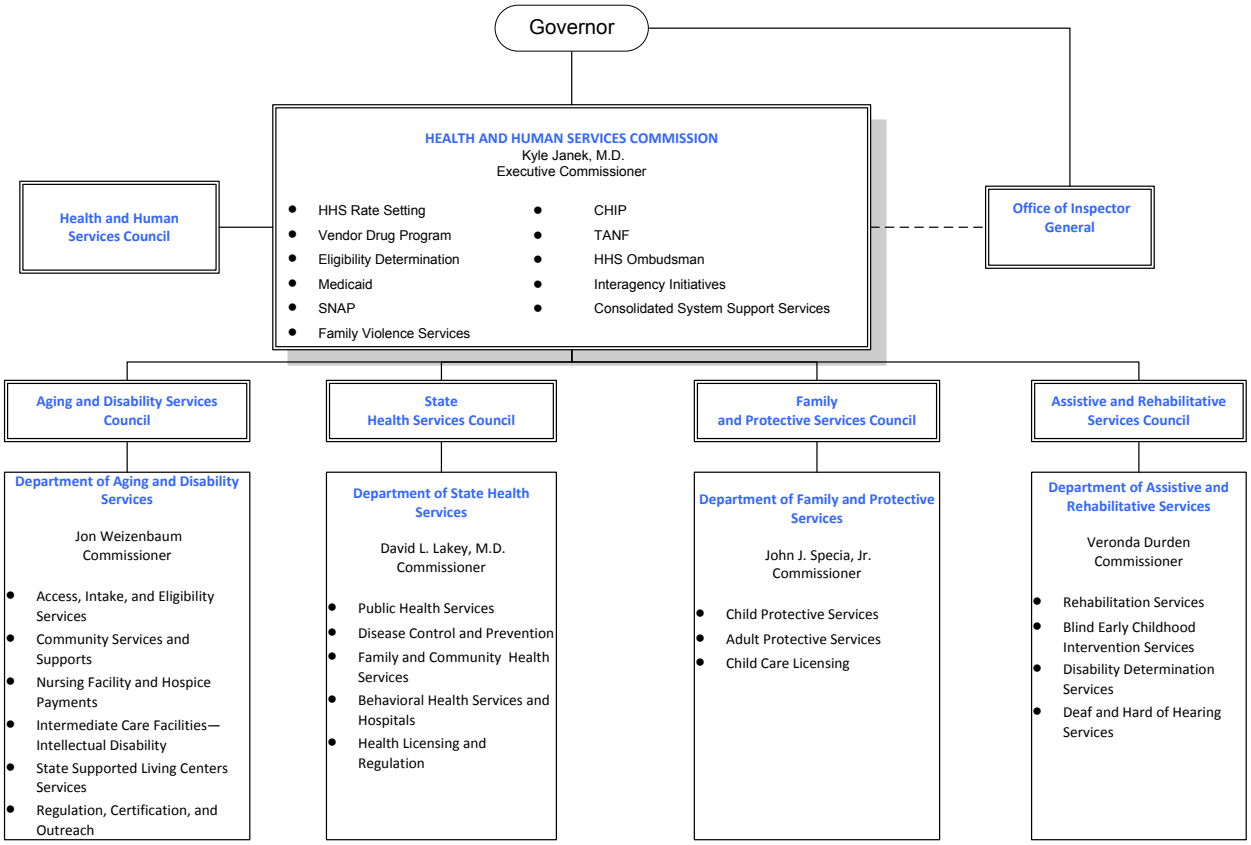
| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| Radioactive Materials and Devices, Health & Safety Code 401.301 & .302 | $110 - $56,060 (plus additional use and subsite fees) | 13,349 | $10,897,872 | General Revenue |
| Public Health Services & Laboratory Services, Various Codes, Health & Safety Code 12.0122, 12.031-12.039 & 12.0127; 25 TAC 73.31, 73.41, 73.51, 73.53 & 73.55 | $2.29 - $2,000 | N/A | $16,503,128 | General Revenue-Dedicated |
| Social Worker Licensing, Occupations Code 505.203, .358, & .402-403 | $10 - $100 | 13,302 | $1,163,007 | General Revenue |
| Adoption Registry Fees, Health & Safety Code 191.0045 & 192.0021 | $30 | 580 | $17,412 | General Revenue-Dedicated |
| Insurance Notification/HIV, Insurance Code 545.055 | $25 | 93 | $1,950 | General Revenue |
| Sex Offender Treatment Providers, Occupations Code 110.159, .307, 451, 452, 458 & 460 | $10 - $375 | 264 | $85,972 | General Revenue |

| Department of State Health Services<br>Exhibit 8: Fee Revenue — Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Fee Description/ Program/ Statutory Citation** | **Current Fee/ Statutory maximum** | **Number of persons or entities paying fee** | **Fee Revenue** | **Where Fee Revenue is Deposited** |
| Health Service Providers, Health & Safety Code 12.014, 12.0111, & 12.0112 | $120 - $500 | 0 | 0 | General Revenue |

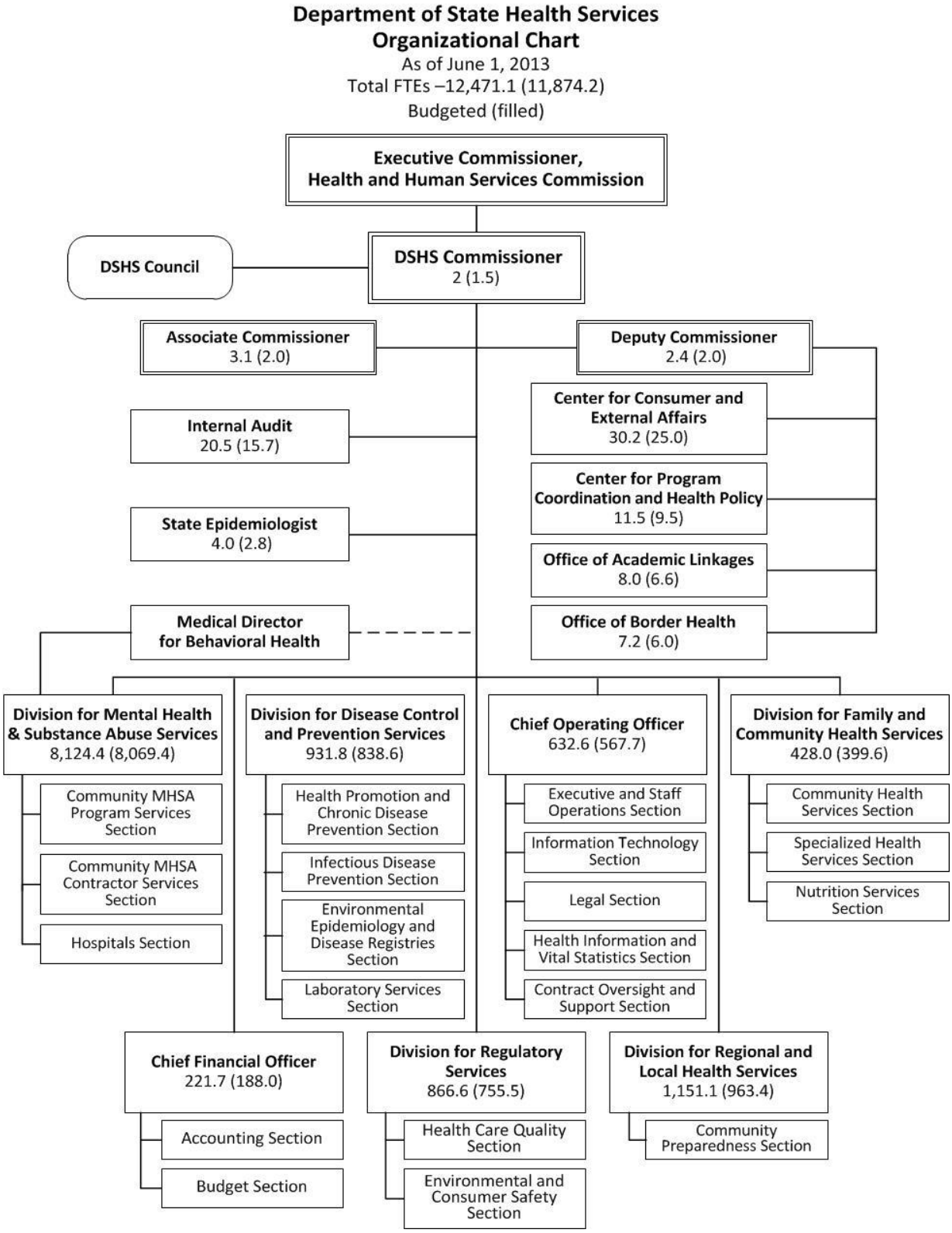
# VI. ORGANIZATION

**A. Provide an organizational chart that includes major programs and divisions, and shows the number of FTEs in each program or division. Detail should include, if possible, Department Heads with subordinates, and actual FTEs with budgeted FTEs in parenthesis.**

The following chart shows the Health and Human Services System organization.



The following chart depicts the Department of State Health Services' (DSHS) organizational structure, including the number of full-time equivalent (FTE) positions budgeted as of June 1, 2013 and the number of filled FTEs in parenthesis.



**B. If applicable, fill in the chart below listing field or regional offices.**

| Department of State Health Services<br>Exhibit 9: FTEs by Location - Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Headquarters, Region, or Field Office** | **Location** | **Co-Located? Yes/No** | **Number of Budgeted FTEs, FY 2013** | **Number of Actual FTEs as of June 1, 2013** |
| State Office-Headquarters | Austin | Mixed | 2,992.3 | 2,663.5 |
| Region 1-Headquarters | Lubbock | Yes | 18.0 | 16.0 |
| Region 1-Headquarters | Canyon | Yes | 9.0 | 8.0 |
| Region 1 | Canyon | Yes | 28.8 | 28.0 |
| Region 1 | Clarendon | No | 2.1 | 2.0 |
| Region 1 | Hereford | No | 2.1 | 2.0 |
| Region 1 | Lubbock | Yes | 50.7 | 49.0 |
| Region 1 | Tulia | No | 2.1 | 2.0 |
| Region 2/3-Headquarters- | Abilene | Yes | 6.7 | 6.0 |
| Region 2/3-Headquarters | Arlington | Yes | 98.9 | 88.0 |
| Region 2/3-Headquarters | Terrell | Yes | 3.4 | 3.0 |
| Region 2/3-Headquarters | Vernon | Mixed | 2.2 | 2.0 |
| Region 2/3-Headquarters | Wichita Falls | Yes | 4.5 | 4.0 |
| Region 2/3 | Abilene | Yes | 8.6 | 8.0 |
| Region 2/3 | Archer City | No | 2.2 | 2.0 |
| Region 2/3 | Arlington | Yes | 93.7 | 87.5 |
| Region 2/3 | Cleburne | No | 2.1 | 2.0 |
| Region 2/3 | Dallas | No | 4.3 | 4.0 |
| Region 2/3 | Duncanville | No | 2.1 | 2.0 |
| Region 2/3 | Gainesville | No | 4.3 | 4.0 |
| Region 2/3 | Granbury | No | 4.3 | 4.0 |
| Region 2/3 | Kaufman | No | 4.7 | 4.4 |
| Region 2/3 | Mineral Wells | No | 2.1 | 2.0 |
| Region 2/3 | Rockwall | No | 1.1 | 1.0 |
| Region 2/3 | Seymour | No | 1.1 | 1.0 |
| Region 2/3 | Stamford | No | 2.1 | 2.0 |
| Region 2/3 | Vernon | Mixed | 2.1 | 2.0 |
| Region 2/3 | Winters | No | 3.2 | 3.0 |
| Region 4/5N-Headquarters | Crockett | Yes | 1.1 | 1.0 |
| Region 4/5N-Headquarters | Rusk | Yes | 3.4 | 3.0 |
| Region 4/5N-Headquarters | Tyler | Yes | 31.5 | 28.0 |
| Region 4/5N | Athens | No | 5.7 | 4.0 |

| Department of State Health Services<br>Exhibit 9: FTEs by Location - Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Headquarters, Region, or Field Office** | **Location** | **Co-Located? Yes/No** | **Number of Budgeted FTEs, FY 2013** | **Number of Actual FTEs as of June 1, 2013** |
| Region 4/5N | Austin | Mixed | 1.3 | 1.0 |
| Region 4/5N | Carthage | No | 1.3 | 1.0 |
| Region 4/5N | Center | No | 2.7 | 2.0 |
| Region 4/5N | Clarksville | No | 1.3 | 1.0 |
| Region 4/5N | Crockett | Yes | 4.0 | 3.0 |
| Region 4/5N | Gilmer | No | 4.0 | 3.0 |
| Region 4/5N | Henderson | No | 4.0 | 3.0 |
| Region 4/5N | Kirbyville | No | 1.3 | 1.0 |
| Region 4/5N | Linden | No | 1.3 | 1.0 |
| Region 4/5N | Livingston | No | 6.7 | 5.0 |
| Region 4/5N | Longview | No | 8.1 | 6.0 |
| Region 4/5N | Lufkin | No | 4.0 | 3.0 |
| Region 4/5N | Marshall | No | 1.3 | 1.0 |
| Region 4/5N | Mount Pleasant | No | 6.7 | 5.0 |
| Region 4/5N | Nacogdoches | No | 10.7 | 8.0 |
| Region 4/5N | New Boston | No | 2.7 | 2.0 |
| Region 4/5N | Palestine | No | 5.4 | 4.0 |
| Region 4/5N | Paris | No | 4.0 | 3.0 |
| Region 4/5N | Sulphur Springs | No | 5.4 | 4.0 |
| Region 4/5N | Texarkana | No | 4.0 | 3.0 |
| Region 4/5N | Tyler | Yes | 76.5 | 57.0 |
| Region 6/5S-Headquarters | Bacliff | Yes | 4.5 | 4.0 |
| Region 6/5S-Headquarters | Beaumont | Mixed | 3.4 | 3.0 |
| Region 6/5S-Headquarters | Houston | Yes | 83.1 | 74.0 |
| Region 6/5S-Headquarters | Tomball | No | 2.2 | 2.0 |
| Region 6/5S | Beaumont | Mixed | 5.3 | 4.0 |
| Region 6/5S | Bellville | No | 5.3 | 4.0 |
| Region 6/5S | Cleveland | No | 4.0 | 3.0 |
| Region 6/5S | Columbus | No | 1.3 | 1.0 |
| Region 6/5S | Conroe | No | 4.0 | 3.0 |
| Region 6/5S | Houston | Yes | 126.3 | 95.0 |
| Region 7-Headquarters | Temple | Yes | 21.3 | 19.0 |
| Region 7-Headquarters | Waco | Mixed | 3.4 | 3.0 |
| Region 7 | Austin | Mixed | 9.1 | 8.0 |
| Region 7 | Bastrop | No | 3.5 | 3.0 |

| Department of State Health Services<br>Exhibit 9: FTEs by Location - Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Headquarters, Region, or Field Office** | **Location** | **Co-Located? Yes/No** | **Number of Budgeted FTEs, FY 2013** | **Number of Actual FTEs as of June 1, 2013** |
| Region 7 | Bryan | No | 1.2 | 1.0 |
| Region 7 | Copperas Cove | No | 1.2 | 1.0 |
| Region 7 | Elgin | No | 2.3 | 2.0 |
| Region 7 | Hearne | No | 2.3 | 2.0 |
| Region 7 | Lampasas | No | 2.3 | 2.0 |
| Region 7 | Lockhart | No | 1.2 | 1.0 |
| Region 7 | Madisonville | No | 1.2 | 1.0 |
| Region 7 | Marble Falls | No | 2.3 | 2.0 |
| Region 7 | Meridian | No | 2.3 | 2.0 |
| Region 7 | Navasota | No | 1.2 | 1.0 |
| Region 7 | Temple | Yes | 77.5 | 67.0 |
| Region 7 | Waco | Mixed | 5.8 | 5.0 |
| Region 8-Headquarters | Bandera | Yes | 1.1 | 1.0 |
| Region 8-Headquarters | Kerrville | Mixed | 1.1 | 1.0 |
| Region 8-Headquarters | San Antonio | Mixed | 79.8 | 71.0 |
| Region 8 | Austin | Mixed | 1.1 | 1.0 |
| Region 8 | Bandera | Yes | 3.1 | 3.0 |
| Region 8 | Boerne | No | 2.2 | 2.0 |
| Region 8 | Cuero | No | 1.1 | 1.0 |
| Region 8 | Del Rio | No | 5.5 | 5.0 |
| Region 8 | Eagle Pass | No | 5.5 | 5.0 |
| Region 8 | Floresville | No | 2.2 | 2.0 |
| Region 8 | Goliad | No | 3.3 | 3.0 |
| Region 8 | Halletttsville | No | 3.3 | 3.0 |
| Region 8 | Karnes City | No | 2.2 | 2.0 |
| Region 8 | Kerrville | Mixed | 2.2 | 2.0 |
| Region 8 | Pearsall | No | 3.3 | 3.0 |
| Region 8 | San Antonio | Mixed | 71.1 | 65.0 |
| Region 8 | Seguin | No | 5.5 | 5.0 |
| Region 8 | Uvalde | No | 8.7 | 8.0 |
| Region 8 | Victoria | No | 1.1 | 1.0 |
| Region 9/10-Headquarters | Big Spring | Mixed | 2.2 | 2.0 |
| Region 9/10-Headquarters | El Paso | Mixed | 15.7 | 14.0 |
| Region 9/10-Headquarters | Midland | Yes | 3.4 | 3.0 |
| Region 9/10-Headquarters | San Angelo | Yes | 2.2 | 2.0 |

| Department of State Health Services<br>Exhibit 9: FTEs by Location - Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Headquarters, Region, or Field Office** | **Location** | **Co-Located? Yes/No** | **Number of Budgeted FTEs, FY 2013** | **Number of Actual FTEs as of June 1, 2013** |
| Region 9/10 | Alpine | No | 4.0 | 3.0 |
| Region 9/10 | Big Spring | Mixed | 1.3 | 1.0 |
| Region 9/10 | Brady | No | 2.7 | 2.0 |
| Region 9/10 | El Paso | Mixed | 68.1 | 51.0 |
| Region 9/10 | Marfa | No | 1.3 | 1.0 |
| Region 9/10 | Midland | Yes | 32.0 | 24.0 |
| Region 9/10 | San Angelo | Yes | 6.7 | 5.0 |
| Region 9/10 | Sonora | No | 1.4 | 1.0 |
| Region 11-Headquarters | Corpus Christi | Yes | 5.6 | 5.0 |
| Region 11-Headquarters | Harlingen | Mixed | 40.4 | 36.0 |
| Region 11-Headquarters | McAllen | Yes | 1.1 | 1.0 |
| Region 11 | Alice | No | 7.3 | 6.0 |
| Region 11 | Beeville | No | 4.8 | 4.0 |
| Region 11 | Brownsville | No | 4.8 | 4.0 |
| Region 11 | Corpus Christi | Yes | 16.9 | 14.0 |
| Region 11 | Edinburg | No | 1.2 | 1.0 |
| Region 11 | Falfurrias | No | 2.4 | 2.0 |
| Region 11 | Harlingen | Mixed | 83.2 | 69.0 |
| Region 11 | Kingsville | No | 2.4 | 2.0 |
| Region 11 | Laredo | No | 15.7 | 13.0 |
| Region 11 | McAllen | Yes | 24.1 | 20.0 |
| Region 11 | Mercedes | No | 13.3 | 11.0 |
| Region 11 | Rio Grande City | No | 12.1 | 10.0 |
| Region 11 | Rockport | No | 1.2 | 1.0 |
| Region 11 | Zapata | No | 2.4 | 2.0 |
| Austin State Hospital | Austin | Mixed | 853.5 | 849.6 |
| Big Spring State Hospital | Big Spring | Mixed | 581.6 | 578.9 |
| El Paso Psychiatric Center | El Paso | Mixed | 251.3 | 250.1 |
| Kerrville State Hospital | Kerrville | Mixed | 535.7 | 533.2 |
| North Texas State Hospital | Vernon | Mixed | 1,108.5 | 1,103.5 |
| North Texas State Hospital | Wichita Falls | Yes | 957.0 | 952.6 |
| Rio Grande State Center | Harlingen | Mixed | 525.5 | 523.1 |
| Rusk State Hospital | Rusk | Yes | 955.3 | 950.9 |
| San Antonio State Hospital | San Antonio | Mixed | 862.0 | 858.1 |
| Terrell State Hospital | Terrell | Yes | 911.9 | 907.7 |

| Department of State Health Services<br>Exhibit 9: FTEs by Location - Fiscal Year 2012 | | | | |
|---|---|---|---|---|
| **Headquarters, Region, or Field Office** | **Location** | **Co-Located? Yes/No** | **Number of Budgeted FTEs, FY 2013** | **Number of Actual FTEs as of June 1, 2013** |
| Texas Center for Infectious Disease | San Antonio | Mixed | 162.3 | 161.6 |
| Waco Center for Youth | Waco | Mixed | 222.5 | 221.5 |
| Office of Violent Sex Offender Management | Austin | Mixed | 25.0 | 20.0 |
| Office of Violent Sex Offender Management | El Paso | Mixed | 1.0 | 1.0 |
| **TOTAL** | | | **12,471.1** | **11,874.2** |

**C. What are your agency's FTE caps for fiscal years 2012-2015?**

Fiscal year 2012 - 12,467.8
Fiscal year 2013 - 12,471.1
Fiscal year 2014 - 12,321.0
Fiscal year 2015 - 12,325.0

**D. How many temporary or contract employees did your agency have as of August 31, 2012?**

DSHS had 78 contracted and temporary employees as of August 31, 2012.

**E. List each of your agency's key programs or functions, along with expenditures and FTEs by program.**

| Texas Department of State Health Services<br>Exhibit 10: List of Program FTEs and Expenditures - Fiscal Year 2012 | | |
|---|---|---|
| **Program** | **FTEs as of August 31, 2012** | **Actual Expenditures** |
| Executive Offices and Centers | 51.6 | 5,058,830 |
| Chief Financial Office | 137.5 | 9,143,386 |
| Chief Operating Office | 154.6 | 38,943,449 |
| Health Information and Vital Statistics | 233.1 | 20,394,395 |

| Texas Department of State Health Services<br>Exhibit 10: List of Program FTEs and Expenditures - Fiscal Year 2012 | | |
|---|---|---|
| **Program** | **FTEs as of August 31, 2012** | **Actual Expenditures** |
| Community Mental Health Services | 80.7 | 442,088,864 |
| Substance Abuse Prevention, Intervention, and Treatment | 84.5 | 138,571,360 |
| NorthSTAR Behavioral Health Waiver | 9.7 | 120,169,145 |
| Hospital Services | 7,851.2 | 475,463,625 |
| Women and Children's Health Services | 449.0 | 78,310,359 |
| Family Planning Services | 13.0 | 23,935,952 |
| Primary Health Care Services | 17.8 | 14,207,006 |
| Specialized Health Services | 133.6 | 59,917,025 |
| Nutrition Services and Obesity Prevention | 322.4 | 755,301,635 |
| Community Capacity Building | 6.9 | 7,951,880 |
| Emergency Medical Services and Trauma | 19.2 | 68,903,514 |
| Food and Drug Safety | 336.8 | 23,396,766 |
| Environmental Health | 115.6 | 7,125,585 |
| Radiation Control | 128.4 | 7,815,605 |
| Healthcare Professionals | 122.4 | 6,876,437 |
| Healthcare Facilities | 110.1 | 9,351,689 |
| Environmental Epidemiology and Disease Registries | 122.8 | 12,875,417 |
| Infectious Disease Prevention | 654.2 | 294,943,769 |
| Health Promotion and Chronic Disease Prevention | 46.5 | 25,494,576 |
| Laboratory Services | 353.3 | 44,177,730 |
| Regional and Local Health Services Administration | 21.1 | 1,525,544 |
| Community Preparedness | 265.8 | 86,852,813 |
| **TOTAL** | **11,862.1** | **2,782,332,351** |

# VII. GUIDE TO AGENCY PROGRAMS

**Narratives**

**Executive Offices and Centers**
David L. Lakey, M.D., Commissioner
Kirk Cole, Associate Commissioner
Luanne Southern, Deputy Commissioner

**FTEs: 71.1**

Commissioner – FTEs: 1.5
The Commissioner serves as the chief administrative head for the Department of State Health Services (DSHS) (also the State's Chief Health Officer) and is responsible for maintaining fiscal responsibility while ensuring that Texans are able to access integrated physical health, mental health, and substance abuse prevention and treatment services in their communities. The Commissioner has executive-level responsibility for the delivery of Department of State Health Services (DSHS) programs and client services.

Associate Commissioner – FTEs: 2.0
The Associate Commissioner has broad involvement in the day-to-day operations of the agency, addressing both program functions and business support functions, and resolving significant issues as needed. Other responsibilities include providing follow-through on key issues and significant projects, proactively initiating action to address agency performance issues, serving as a catalyst to organize and initiate action on projects cutting across agency divisions, and ensuring proper agency communications and interaction with stakeholders.

Deputy Commissioner – FTEs: 49.1
The Deputy Commissioner works closely with the DSHS Commissioner to guide program policy direction, external communications, government affairs, consumer affairs, and linkages with external organizations impacting agency constituents and operations. Duties include providing leadership to and oversight of agency's priority initiatives, rules coordination, and bi-national health initiatives on the Texas-Mexico border. The Deputy Commissioner directs the Center for Consumer and External Affairs, the Center for Program Coordination and Health Policy, the Office of Academic Linkages, and the Office of Border Health. The Deputy Commissioner and staff also develop and monitor plans to implement agencywide health policy initiatives, coordinate efforts to integrate program services, and serve as the executive point of contact for, and communicate regularly with, members of the State Health Services (SHS) Council. Description of the duties of above-mentioned executive centers and offices follows.

- Center for Consumer and External Affairs (CCEA) is responsible for DSHS internal and external communications, stakeholder and legislative relations, and strategic planning. CCEA processes consumer complaints and inquiries and coordinates the referral of

complaints and inquiries to the appropriate division, provides guidelines in support of advisory committees, and supports the correspondence and memoranda processes of the Commissioner's Office. CCEA also coordinates the agency's rule process and SHS Council activities.

The CCEA Communications Unit plans and assists programs with communication strategies, oversees agencywide internal communications, translates agency materials into appropriate languages, develops communications products for executive staff, conducts public awareness and education campaigns, and develops and maintains agency webpages related to communications and emergency public information. The CCEA Government Affairs Unit serves as the liaison with state and federal elected officials, coordinates responses to requests from legislative offices and the Governor's office, and coordinates DSHS activities during legislative sessions. The CCEA Media Relations Unit responds to media inquiries.

- Center for Program Coordination and Health Policy (CPCHP) provides agencywide planning, coordination, and health policy analysis. CPCHP team members also:
    - coordinate Medicaid policy issues with DSHS programs;
    - oversee, coordinate, and communicate program changes occurring due to the implementation of the Affordable Care Act;
    - oversee the development of health information technology policies across the agency;
    - provide project management consultation for agency priority initiatives;
    - manage internal quality improvement grant initiatives for the agency;
    - support healthcare quality data initiatives across the agency and HHS System;
    - provide program support and technical assistance concerning the use of data to regional medical centers regarding adult potentially preventable hospitalizations;
    - manage weekly executive meetings and quarterly executive strategic planning efforts; and
    - manage special projects for the Commissioner and Deputy Commissioner.

- Office of Academic Linkages (OAL) serves as the focal point in DSHS for supporting and strengthening current partnerships and for seeking opportunities for increased linkages with academic institutions. With priority focus on the health workforce essential to accomplishing DSHS' mission, OAL is the home for the agency's health professional development functions.

  OAL is responsible for the implementation and administration of the DSHS' Preventive Medicine Residency Program. For other health professionals, OAL establishes partnerships with educational institutions to provide internship opportunities for students in service areas and programs within DSHS. OAL also provides administrative support to the Research Executive Steering Committee, established in 2011 to conduct management and policy review of research projects. The OAL director is designated as the agency's Authorized Institutional Official in accordance with federal regulations 45 C.F.R., §46.112 and DSHS

policy to provide oversight for adherence to federal regulations regarding the involvement of human subjects in biomedical and behavioral research.

- Office of Border Health (OBH) leads agency bi-national efforts to reduce community and environmental health hazards along the Texas-Mexico border. In collaboration with border communities, and the United States and Mexican local, state, and federal health entities, OBH works to address health issues facing border residents. OBH serves as the Texas outreach office for the United States-Mexico Border Health Commission, the U.S. Department of Health and Human Services, and the Office of Global Health Affairs. OBH employs staff at DSHS headquarters in Austin and in five field offices – Harlingen, Laredo, San Antonio, Eagle Pass, and El Paso in health service regions 8, 9/10, and 11.

Office of Internal Audit – FTEs: 15.7
The Office of Internal Audit (OIA) provides independent appraisal and analysis of governance, control, and risk mitigation processes to assist management in enhancing services. The Office of Internal Audit conducts audits of agency processes and operations in accordance with the annual audit plan, or at the DSHS Commissioner's request. The OIA prepares the annual audit plan using a risk-assessment methodology that helps auditors select the areas of higher risk for review. The audit plan also reserves resources for special projects and consulting activities that the Commissioner or his direct reports may request.

State Epidemiologist – FTEs: 2.8
The State Epidemiologist provides general guidance to DSHS programs on epidemiologic and scientific matters and serves as the primary point of contact on epidemiologic matters with the Centers for Disease Control and Prevention and other federal agencies. The State Epidemiologist works closely with the Commissioner, Associate Commissioner, Deputy Commissioner, Assistant Commissioners, and others to enhance agencywide epidemiologic activities, including disease surveillance, response to outbreaks or other unusual expressions of disease, and the application of agency data to improve public health.

**Chief Financial Officer (CFO)**
Bill Wheeler

**FTEs: 188.0**

The CFO is responsible for the agency's strategic planning, budgeting process, and financial operation. Tasks include developing fiscal policies and procedures, ensuring the integrity of accounting records, safeguarding financial assets through the establishment and maintenance of internal control, and assisting the agency in resolving issues for financial functions handled by the Health and Human Services Commission (HHSC), such as administrative procurements and regional administrative services.

Accounting Section
This section is responsible for agency disbursements, accounts receivables, billing and collection, cash management, maintenance of the agency's books of record, and preparation of the annual financial report in accordance with generally accepted governmental accounting standards. In addition, the section coordinates financial audits and processes reimbursements.

Budget Section
This section develops the Legislative Appropriation Request and fiscal notes for bills and rules; develops and manages the agency's budget; provides performance measurement reporting; conducts statistical analysis, forecasting, and trend analysis; and provides contract management support. The section also conducts federal funds reporting, supports development of grant applications, prepares budgets and funding projections for grants and interagency agreements, and coordinates and reviews grant awards and interagency agreements.

Note: Other program strategies fund some staff organizationally assigned to CFO. The above FTE count includes these staff but the FTE count for Section VI.E does not include these staff.

**Chief Operating Officer (COO)**
Ed House

**FTEs: 567.7**

The COO oversees operations, business continuity activities, property and building management, print services, legal services, information technology, and contract oversight and support. The COO is also responsible for coordination with HHSC to ensure the effective and efficient delivery of administrative support services. Additionally, the COO oversees programs that manage the State of Texas' vital records and collects, analyzes, and publishes health data and information.

Operations Management Unit
This unit provides direct functional support to DSHS executive management in the development, management, and implementation of operational and administrative policies and strategies; coordinates with Health and Human Services (HHS) System agencies on projects and workgroups; and conducts business continuity planning. HHSC provides centralized services for human resources and civil rights.

Executive and Staff Operations Section
This section supports DSHS infrastructure needs. The section provides support for internal DSHS customers in the areas of property management and space planning, building services, fleet management, and reception and switchboard services. The section also serves as the liaison with the Texas Facilities Commission for maintenance and repairs at the DSHS central

campus. This section manages the consolidated HHS printing service, which provides full service graphics, printing, binding, photocopying, and distribution services.

Information Technology (IT) Section

This section provides IT services, including IT security, to DSHS under the direction of the Information Resources Manager. The IT Business Services Office provides IT planning and reviews capital and technology purchases. The Application Development Unit provides application development services, including support of existing application systems; development of new application systems; and consultation, coordination and management of outsourcing application systems. This unit also manages, maintains, and supports the agency's Internet and Intranet websites. The Project Management Office provides guidance, services, support, and expertise related to IT governance and project management best practices, quality assurance reviews of documentation and reporting for major IT projects, project portfolio management resulting in the annual service delivery plan, project status reporting and documentation support, and coordination of IT projects across the agency.

The Operations Unit manages and provides operational support for the core IT infrastructure; agencywide e-mail services, desktop and audiovisual support, data center services, IT asset management, mobile technology, e-mail, and computer hardware. This support includes on-site staff throughout the state for ongoing daily support of the State Hospitals, health service regions, the Austin headquarters and metro locations, and Women, Infants, and Children (WIC) program clinics.

The Information Security Office provides agencywide information security analysis, risk management and mitigation, and guidance to protect the agency's information resources and to ensure a safe and secure computer environment to conduct agency business. The Health Information Technology (HIT) area is responsible for providing public health information technology architecture and technical strategy for the agency. This area is also responsible for directing the development of agency and state policies, guidelines, procedures, rules, and regulations for health information architecture, standards, interoperability between systems, and data exchange.

The HHSC IT division has the responsibility of planning and managing information resources across the HHS System. HHS Circular C-009, Enterprise IT Governance Policy establishes centralized information systems planning mechanisms and responsibilities for IT management across the HHS System.

Office of General Counsel (OGC)

OGC provides legal support to DSHS regarding personnel and employment law matters, as well as to DSHS programs and state-operated facilities. OGC represents regulatory programs in enforcement hearings, provides hearing officers for certain due-process hearings, and coordinates litigation for the agency. The Government Law Unit provides legal services to the non-regulatory divisions of DSHS and legal support for the agency's administrative functions

involving contracts as well as legal support for agency personnel matters and legal advice to the state-operated facilities. This unit also includes the Public Information Coordinator. The Enforcement Unit provides legal services primarily to the DSHS regulatory programs, the Vital Statistics Unit, and the Center for Health Statistics. This unit includes staff that coordinates the agency's rulemaking activities and *Texas Register* filings.

Contract Oversight and Support Section

The section is the central oversight authority for contract management and monitoring, charged with developing agencywide contract policies and procedures to ensure consistency throughout all elements of agency contracting. This section also leads internal and external training for DSHS staff, contractors, and contracting personnel. The section conducts quality assurance and follow-up monitoring reviews to ensure compliance with contracting policies and procedures, as well as state and federal rules and regulations. The fiscal risk assessment for sub-recipient contractors is prepared annually and reviewed semi-annually. The section also provides technical assistance to DSHS program staff and contractors on matters pertaining to financial management of contracts, including interpretation of applicable federal and state laws/regulations. The Contract Oversight and Support Section maintains agencywide records of contractor fiscal documents. HHS System Contract and Procurement Services housed at HHSC provides and directs the purchasing and contracting activities for the HHS agencies and directly purchases certain administrative goods and services for DSHS programs.

Health Information and Vital Statistics

This section consists of two units, the Center for Health Statistics and the Vital Statistics Unit. Detailed information about this program is included in a separate Section VII description.

## VII. GUIDE TO AGENCY PROGRAMS

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Health Information and Vital Statistics |
| **Location/Division** | 1100 W. 49th Street, Austin – Chief Operating Officer (COO) |
| **Contact Name** | Ed House, COO |
| **Actual Expenditures, FY 2012** | $20,394,395 |
| **Number of Actual FTEs as of June 1, 2013** | 231.4 |
| **Statutory Citation for Program** | Vital Statistics: Chapter 191, Texas Health and Safety Code; Texas Health Care Information Council: Chapter 108, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Health Information and Vital Statistics has the following primary objectives.

- Improve health status through preparedness and information.
- Enhance state and local public health systems' resistance to health threats, preparedness for health emergencies, and capacities to reduce health status disparities.
- Provide health information for state and local policy decisions.
- Establish credibility as the source of relevant, accurate, and timely vital statistics.

Health Information and Vital Statistics is composed of the Center for Health Statistics (CHS) and the Vital Statistics Unit (VSU).

Major activities of CHS include the following.

**Health Information Resources**

The Health Information Resources Branch provides statistical data for births, deaths, fetal deaths, infant deaths, abortions, marriages, and divorces for the state. An array of technical expertise on demographic methods, statistical methods, community assessments, and analytical methods resides here. CHS staff has developed a complex algorithm, which the Branch uses to match newborn screening results with Medicaid eligibility data to ensure that Texas receives compensation for Medicaid-eligible screenings. Other protocols reconcile Department of Aging and Disability Services client data to death data; and birth and infant death data to data from the Texas Birth Defects Registry, the Texas Cancer Registry, and research projects approved by the Institutional Review Board (IRB). This branch reviews research requests for birth, death, infant or fetal death, abortion, marriage, or divorce datasets,

and directs the requests to DSHS' IRB for approval. Additionally, the branch supplies geographic information systems data and mapping to several DSHS programs, emergency operations, and external customers.

**Health Provider Resources**

The Health Provider Resources Branch researches the types and sources of workforce-related data needed to address current and future staffing levels of healthcare professions, especially for nurses in Texas. The branch conducts an annual statewide survey of hospitals on financial data, utilization rates, uncompensated care, and community benefits in conjunction with the American Hospital Association and the Texas Hospital Association. The Branch designates sites as Medically Underserved Populations, so that physician assistants and nurse practitioners have permission to write prescriptions in accordance with Title 25, Chapter 13, Subchapter C, Texas Administrative Code.

**Texas Health Care Information Collection (THCIC)**

THCIC, formerly known as the Texas Health Care Information Council, collects inpatient and a subset of outpatient data, under Chapter 108, Texas Health and Safety Code. Beginning in 2014, THCIC will also collect emergency department data. THCIC staff produces annual reports on the quality of inpatient care in Texas hospitals and pediatric hospitals and the incidence of preventable hospitalizations. Staff is currently developing reports on potentially preventable complications and preventable readmissions; staff will develop reports on preventable emergency visits upon receiving emergency department data. The THCIC team is working with DSHS IT staff to house and post an inpatient data-viewing program for the public. The team trains hospital and ambulatory surgical center staff to submit data, correct and certify the data, and track and monitor the data. THCIC staff works with facilities to comply with the law, rules, and submission requirements and, if needed, works with the Office of General Counsel on enforcement of penalties. The team collects data from Texas health maintenance organizations (HMOs) and transfers that data to the Office of Public Insurance Counsel for publication. THCIC staff produces and markets public use data files, inpatient, outpatient, and, in the future, emergency department data; and creates customized research data files that contain data not included in the public use data files, which require DSHS IRB approval prior to release. THCIC staff addresses many ad hoc data requests from executive leadership and legislators throughout the year. Staff also maintains a registry of healthcare providers and referral groups available to provide life-sustaining treatment or other services relating to the Texas Advance Directives Act.

House Bill 1394, 83rd Legislature, Regular Session, 2013, subjects THCIC to a separate Sunset Advisory Commission review. The review is to consider whether THCIC meets legislative intent, maintains privacy and security, and limits data collection to that which is relevant to statutory purposes. THCIC is abolished, effective September 1, 2015, unless continued by the Legislature.

**Library and Information Services**
The Library and Information Services Program delivers services to improve the efficiency and effectiveness of DSHS and to promote healthy and safe lifestyles. The Library provides information on health-related funding opportunities to hundreds of communities statewide and offers training on grant writing, research skills and resources, and effective management of agency records. The Library and Information Services Program also oversees records management and retention issues for DSHS, and provides library research support and resources to HHS system employees, and statewide access to health and safety audiovisuals.

**State Health Coordinating Council and IRB Support**
DSHS staff provides administrative support for the Statewide Health Coordinating Council (SHCC) and the DSHS IRB. SHCC, a 17-member body comprised of 13 Governor-appointed members, has statutory oversight over the Health Professions Resources Center (HPRC) and the Texas Center for Nursing Workforce Studies. SHCC works with the HPRC to assess the adequacy of the health professions workforce, identify issues, and propose solutions through the Texas State Health Plan. The IRB is responsible for human subjects' protection at DSHS and serves as the scientific review panel for research related to hospital inpatient discharge data.

Major activities of VSU include the following.
**Statewide Source of Demographics**
VSU provides the basic, ongoing demographic measures of the state's population, serving as the cornerstone for public health assessment, assurance, and policy development.

**Statewide Depository and Archive of Vital Records**
VSU is the repository for original records for births and deaths that have occurred in Texas from 1903 to the present. Marriage license applications are available from 1966 to the present. Divorce data are available from 1968 to the present. Vital statistics records exist in many formats, from bound volumes of original paper certificates and microfilm, to the newer fully implemented electronic registered records and digitized graphic images of records.

**Registration of Statewide Vital Events**
The Vital Registration Branch administers both the paper-based and electronic vital records registration systems that ensure that all Texas births, deaths, fetal deaths, applications for marriage, and reports of divorce and annulment are properly registered. The Records Receiving Group is responsible for receiving, visually reviewing, numbering, binding, and data entry of all manually registered vital records. These include birth, death, fetal death, application for marriage license, and suit affecting the parent-child relationship records. The Texas Electronic Registrar (TER) is an integrated, internet-based system that is distributed, managed, and supported by VSU for the registration of birth, death, and marriage events. Hospitals, birthing centers, midwives, and local registrars use TER to electronically register and certify birth events; funeral homes, physicians, justices of the peace, medical examiners, and local registrars use TER to electronically register and certify death events; and county clerks use TER to electronically submit marriage applications.

**Certified Issuance and Maintenance of Vital Records**

The Request Processing Branch (RPB) issues statutorily prescribed, certified copies of vital records for Texas birth and death records and verifications for birth, death, marriage, divorce, and annulment events. The branch also maintains vital records by creating new birth records based on adoption or paternity determinations and processing amendments to birth and death records that correct or complete information on the original vital record. Historically, the RPB has used certified copies of vital records for the following:

- civil registration,
- public health,
- legal documentation linked to citizenship and identification,
- monitoring of population growth,
- surveillance of vital events and sentinel health events,
- public health assessment,
- monitoring of key health indicators,
- identification and tracking of racial and ethnic health disparities and other subgroup analyses,
- identification of population-based risk factors for adverse outcomes, and
- assessments of regional and local health status and services.

**Field Services**

The Field Services Group prepares curriculum and training materials for vital records professionals from local, state, and federal agencies; conducts training conferences; hosts a Master Registrar Certification course; and provides specific training upon request for agencies and organizations. The group also explains vital statistics statutes, rules, regulations, policies, and procedures to the public and vital records professionals; and maintains provider and public websites with current information. The group conducts visits to local registrar offices, hospitals, and birthing centers to ensure compliance with state statutes and codes. Staff also assists vital records professionals with registration on the TER system.

**Vital Statistics Registries**

The Vital Statistics Registries is responsible for the collection, maintenance, and distribution of various statutorily mandated registries, several of which provide information related to paternity and continuing legal jurisdiction over children. The listing of these registries follows.

- Paternity Registry is a putative father registry that permits a man alleging to be the biological father of a child to assert his parentage, independent of the mother, and preserve his rights as a parent.
- Acknowledgment of Paternity Registry provides an administrative process that allows a man and a woman jointly to acknowledge paternity of a child. A valid acknowledgment of paternity filed with VSU is the equivalent of an adjudication of the paternity of a child and confers on the acknowledged father all rights and duties of a parent.
- Court of Continuing Jurisdiction Registry, maintained by VSU since 1995, is the central record file that identifies courts of continuing, exclusive jurisdiction for children in Suits

Affecting the Parent Child Relationship cases. All further action must begin in that court and failure to do so can result in a voidable decree.

- The Department of Family and Protective Services (DFPS) originally developed the Adoption Index system to track Texas adoptions in 1986. In September 1996, Texas Department of Health accepted responsibility for the Adoption Index system. Adoption staff tracked all adoptions in this system from September 1996 until December 2005 when staff began using the TER system. DSHS staff enters all records from child-placing agencies that have gone out of business, cross-referencing the birth family information with the adoptive parent information. Staff also enters adoptions when DSHS receives a Health Social Education Genetic History (HSEGH) new or updated report, so that the HSEGH can be cross-referenced. DSHS previously entered out-of-state births for those adopted in Texas, but no longer has the resources to index these adoptions.
- Central Adoption Registry (CAR) is the umbrella of all the Texas Voluntary Adoption Registries and is part of a voluntary mutual-consent registry system mandated by Chapter 162, Texas Family Code, during the 68th Legislature, 1983. This service enables an adult adoptee, birth parent, and biological sibling the opportunity to locate one another without going through the court system or spending excessive amounts of time and resources through other sources. This registry is unique in that it has the authority, without a court order, to view a sealed or confidential record to authenticate a match between two biologically related people. The CAR maintains a database of all adoptees, birth parents, and siblings, who are looking for one another and who have registered with the CAR or another voluntary adoption registry.

**Vital Statistics Business Modernization Program/Business Operations Unit**

VSU implemented the Business Modernization Program in December 2012 to update the business architecture foundation used to collect, analyze, and share vital statistics data. A director, eight employees, and two contractors staff the program.

The effort will identify current financial cycles and implement business controls to ensure accountability, transparency, and efficiency. IT modernization will improve data quality, as well as VSU's ability to share data securely with partners. The program will develop a reliable and secure information management and analysis framework to provide better systems for users, enhance data integrity, and provide improved analytical capability. The primary objectives are to conduct a cost analysis, determine the appropriate funding model, transition to a balanced operating budget, define responsibilities essential to establishing financial and business operations, and operationalize process improvements.

VSU will implement recommendations from the Rider 72 Workgroup Report (2012-2013 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011); the Vital Statistics Operational Assessment Report; and the Strategic Consolidation Project and Strategic Plan Review, including call center improvements. The target date for completion of the Business Modernization Program is November 2014; however, the Business Operations Unit will be a permanent organization unit.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

Health Information and Vital Statistics use the following key statistics and performance measures to determine effectiveness and efficiency.

| Key Performance Measures | FY 2012 Target | FY 2012 Actual Performance |
|---|---|---|
| Average Successful Requests - Pages per Day | 2,400 | 2,420 |
| Average Number Working Days Required by Staff to Complete Customized Requests | 3 | 1.4 |
| Average Number of Days to Certify or Verify Records | 14 | 11.1 |
| Record Services Completed | 675,000 | 1,461,488 |

| Vital Statistics Registration Event Type | FY 2012 Number of Events Registered |
|---|---|
| Births | 389,955 |
| Deaths | 176,814 |
| Fetal Deaths | 2,116 |
| Suits | 143,251 |
| Marriages | 190,512 |

| Imaging Project Record Set | Number of Years Imaged | Number of Records Available for State Use |
|---|---|---|
| Births and Deaths | 108 | 28,200,000 |

| Total Vital Records Issued, By Type | FY 2009 | FY 2010 | FY 2011 | FY 2012 |
|---|---|---|---|---|
| Birth Certificate | 250,676 | 252,977 | 283,590 | 281,121 |
| Birth Verification | 6,498 | 4,872 | 6,592 | 6,375 |
| Death Certificate-1st Copy | 76,609 | 108,760 | 148,755 | 176,577 |
| Death Certificate-Additional | 420,189 | 661,624 | 939,113 | 1,116,180 |
| Death Verification | 897 | 714 | 889 | 1,067 |
| Divorce Verification | 1,256 | 1,310 | 1,261 | 1,781 |
| Heirloom Birth Certificate | 1,574 | 1,526 | 1,453 | 1,461 |
| Marriage Verification | 2,490 | 2,789 | 2,218 | 2,044 |
| Not Found Birth | 6,409 | 5,388 | 4,713 | 4,255 |
| Not Found Death | 1,720 | 1,608 | 1,962 | 1,891 |

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**2002** – The legacy Texas Department of Health creates CHS to be the focal point for the collection, analysis, and dissemination of health-related information to evaluate and improve public health.

**2004** – DSHS consolidates the Library and Information Services Program (Audiovisual, Medical and Research and Early Childhood Intervention/Rehabilitation Libraries, Funding Information Center, Publications Management Program, Records Management), the hospital inpatient discharge data program, and the Texas Center for Nursing Workforce Studies into CHS.

**2005** – VSU implements the TER online birth registration system and an in-house customer service system. These initiatives reduce the average days to register a birth from 35 days to 5 days. VSU also implements a new online record ordering system via Texas Online.

**2006** – VSU initiates the TER online death registration system and imaging project to image 46 million vital records. These initiatives decrease the average days to register a death from 39 days to 11.

**2007** – House Bill 1739 requires that deaths be registered electronically after August 31, 2008.

**2008** – VSU renegotiates the imaging project to image 26.9 million vital records.

**2009** – VSU implements a new online marriage registration system. Senate Bill 79 requires VSU to issue free birth certificates to DFPS for adoptions. Legislation also passes that requires that marriage licenses are amendable and that VSU accept or reject applications for amendments within 30 days of receipt.

**2010** – VSU renegotiates the imaging project to image 30.4 million vital records.

**2011** – VSU expands the Electronic Print Capture functionality to include all electronically filed supplemental records. This feature auto-generates images for electronically filed supplemental records on a daily basis, making them available for staff to access the following day.

**2012** – VSU completes the remaining imaging of non-standard records with the assistance of the imaging vendors and forms a dedicated internal team to take over the ongoing imaging of vital records. As required by the 2012-2013 General Appropriations Act, H.B. 1, 82nd Legislature (Article II, DSHS, Rider 72), DSHS submits a workgroup report to legislative offices on the security of vital records.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

**Health Statistics**

Health Statistics activities affect any person or organization needing health-related data in Texas. Additionally, staff works closely with local health departments, schools of public health and other universities, other state agencies, legislative offices, and the following committees.

- Statewide Health Coordinating Council (SHCC) is a 17-member council that seeks to ensure healthcare services and facilities are accessible to all citizens by making recommendations to the Governor and the Legislature through the Texas State Health Plan.
- Texas Center for Nursing Workforce Studies Advisory Committee is a steering committee that develops priorities and makes policy recommendations regarding nursing workforce issues.
- Health Survey Users Group is a stakeholder workgroup that guides the development of the annual Texas Behavioral Risk Factor Surveillance System (BRFSS) and provides an avenue of communication and collaboration among BRFSS stakeholders in the state.
- Youth Risk Behavior Survey (YRBS) Health Survey Users Group is a stakeholder workgroup composed of 35 members representing internal and external partners as well as local health districts and school district administrations. The group guides the development of the YRBS, functions as an advisory group and a sounding board for the YRBS program, and assists in the dissemination of YRBS data.
- The Hospital Data Collection Workgroup advises DSHS staff on issues relating to the collection and dissemination of hospital inpatient discharge data.

The CHS website received approximately 2,300 valid hits per day in fiscal year 2012. CHS webpages received about 3 percent of the DSHS daily web traffic and about 3.6 percent of the DSHS website file downloads.

CHS developed its website to provide the most commonly requested information with the goal of minimizing staff effort in responding to requests for data. CHS still receives many ad-hoc requests that involve complex analysis or custom combinations of data items. CHS responded to approximately 2,420 custom data requests in fiscal year 2012. External customers including researchers, students, nonprofit organizations, grant applicants, business consultants, members of the legislature, and the media, made 50-60 percent of the custom data requests in fiscal year 2012.

The Library and Information Services Program responds to approximately 1,100 reference and research requests annually with 55 percent coming from HHS System employees and 45 percent coming from external Texas customers, mostly Funding Information Center research requests from nonprofit organizations and government entities. The Library retrieves

approximately 4,100 journal articles annually. About 95 percent of the articles are for HHS employees and the remainder is for external customers, including reciprocal agreements with other libraries in the United States. Customers circulate or access electronically approximately 5,500 books and audiovisuals each year. Twenty percent of the borrowers are HHS employees and 80 percent are external customers, mostly Texas health educators, contractors, and rehabilitation counselors. Since 1990, the Funding Information Center has helped Texas organizations bring at least $223 million in government and private grants to the state to support health-related programs and services. The Records Management Office provides consultation and training to DSHS employees to encourage the economical and efficient management of departmental records, in accordance with policies and rules, and responds as needed to questions from the public.

**Vital Statistics**

Vital Statistics activities affect:

- federal and local governments and other state and DSHS programs that use vital record information to populate other databases for health planning;
- state government agencies, such as the Office of the Attorney General and DFPS, that use vital record information for child-related court action;
- members of the public who need vital records for access to essential services;
- other programs that use data for tracking and health planning;
- CHS, which uses vital records information for planning and analysis;
- federal, state, and local governments and other HHS programs that use vital records data to prevent fraudulent use of services and benefits;
- adoption agencies; and
- local registrars who receive training and guidance to ensure accurately completed records.

In fiscal year 2012, VSU processed 408,772 orders and issued 1,549,261 record service transactions. The breakdown by type of customer follows.

| **General Public:** | **Number** | **Percentage** |
|---|---|---|
| Texas Online Orders | 131,520 | 32.17% |
| Mailed In Orders | 88,933 | 21.76% |
| Lobby Orders (Cash/ Check/ Money Orders) | 26,834 | 6.56% |
| Lobby Orders (Credit Card) | 9,017 | 2.21% |
| **Funeral Homes:** | | |
| Death Certificate Ordering Application | 152,468 | 37.30% |
| **Total Orders** | 408,772 | 100% |

| **Texas Electronic Registrar (TER) Enrollment, By Source Provider** | **Number** | **Percentage** |
|---|---|---|
| Total Physicians Enrolled in TER | 25,661 | 77% |
| Total Funeral Directors Enrolled in TER | 5,391 | 16% |
| Total Funeral Homes Enrolled in TER | 1,614 | 4% |

| Texas Electronic Registrar (TER) Enrollment, By Source Provider | Number | Percentage |
|---|---|---|
| Total Justices of the Peace Enrolled in TER | 814 | 2% |
| Total Local Registrars Enrolled in TER | 316 | 1% |
| **Total Enrollment** | **32,982** | **100%** |

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

CHS and VSU both reside in the Chief Operating Office. DSHS subdivides CHS into the Health Information Resources Branch, the Health Provider Resources Branch, the Health Care Information Collection Team, and the Library and Information Services Program.

VSU includes the Request Processing Branch and the Vital Registration Branch. VSU has oversight and monitoring responsibility for 471 local registrars. Flowcharts and policy and procedure manuals are available for review at:
http://online.dshs.state.tx.us/vs/rpmanual.shtm.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/coo.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $7,365,172 |
| General Revenue | $5,635,414 |
| General Revenue-Dedicated | $2,552,936 |
| Other | $4,840,873 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Local registrars | Both VSU and local registrars register vital events; collect | Local registrars cannot make supplemental changes associated |

| Name | Similarities | Differences |
|---|---|---|
| | birth, death, marriage, divorce, and fetal death records; and issue and sell copies and certified copies of these records. | with vital records such as corrections (amendments), adoptions, or changes in paternity. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

Chapter 191, Texas Health and Safety Code, establishes VSU to administer the registration of vital statistics for Texas. Section 191.003, Texas Health and Safety Code, requires the appointment of a Director/State Registrar and the issuance of detailed instructions by the State Registrar for the uniform observance and maintenance of a perfect system of registration. The powers and duties required by the Health and Safety Code are specific to VSU; therefore, local registrars and others cannot duplicate VSU function or activities.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Local registrars | Vital events statutorily require dual registration in Texas. | Local registrars are required to file a vital event locally and forward onto the state level. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| National Center for Health Statistics (NCHS) | NCHS provides U.S. public health statistics, including diseases, pregnancies, births, aging, and mortality. | DSHS has entered into several memoranda of understanding and contracts to provide vital records data to the NCHS. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**

- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts in this program for the following:
- web portal for vital records,
- data collection and management, and
- library subscriptions.

Amount of contracted expenditures in fiscal year 2012: $1,490,115
Number of program contracts: 14 (includes contracts with no expenditures)

The top contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $782,304 | System-13, Inc. | Data collection, auditing, and warehousing |
| $324,558 | Clearwater | Texas Behavior Risk Factor Surveillance |
| $60,221 | WT Cox | Library subscriptions |
| $27,050 | Genesis Systems, Inc. | Web portal for VSU |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs targeted financial compliance reviews and provide consultative services and technical assistance on financial management of contracts. DSHS staff uses an automated contract management system (SOURCE.Net) to document contractor information, contract management activities, and monitor reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

The program does not award any grants.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory change to assist the program in performing its functions.

**Chapter 108, Texas Health and Safety Code** – DSHS recommends revision of the statute to allow sharing of healthcare discharge data with other programs at DSHS and other HHS System

agencies using personal identifiers. DSHS recommends amendments to clean up legacy agency language and to remove exemptions that rural hospitals currently have from submitting discharge data.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

**Mental Health and Substance Abuse (MHSA) Services Division**
Mike Maples, Assistant Commissioner

**FTEs: 8,069.4**

The MHSA Services Division provides oversight, monitoring, and strategic direction for programs that address community mental health services, substance abuse services, and hospital services. Additionally, the division administers the activities associated with NorthSTAR, the behavioral health managed care program in the Dallas service area (Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties). Detailed information about each of these services is included in a separate Section VII description.

The division functionally includes three sections that report to the Assistant Commissioner. The sections and their functions are listed below.

- The Community MHSA Program Services Section administers mental health and substance abuse programs and policy.
- The Community MHSA Contractor Services Section administers mental health and substance abuse program contracts and quality management.
- The State Hospital Services Section provides oversight of nine state mental health hospitals, a psychiatric residential treatment facility for adolescents, a public health hospital, and a public health outpatient clinic to ensure the delivery of services.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Community Mental Health Services |
| **Location/Division** | 909 West 45th Street, Austin – Mental Health and Substance Abuse (MHSA) Services Division |
| **Contact Name** | Mike Maples, Assistant Commissioner, MHSA Services Division |
| **Actual Expenditures, FY 2012** | $442,088,864 |
| **Number of Actual FTEs as of June 1, 2013** | 81.0 |
| **Statutory Citation for Program** | Chapters 531-535, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Community Mental Health Services (CMHS) has as its primary objective to provide quality family-focused, community-based mental health services and supports to adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Major activities include the following.

**State Mental Health Authority (SMHA) Activities**

DSHS serves as the SMHA for mental health services in Texas. Responsibilities include the following:

- oversees the public system of care for adults with SMI and children/adolescents with SED;
- designs and implements policy relating to mental health services;
- contracts with providers for services for the priority populations;
- develops rules relating to the delivery of mental health services;
- defines optimal outcomes for treatment;
- provides technical assistance to contracted providers;
- monitors compliance and issues sanctions when needed; and
- serves as a Medicaid operating agency under HHSC for selected mental health programs provided to eligible adults with SMI and children/adolescents with SED. Under S.B. 58, 83rd Legislature, Regular Session, 2013, the SMHA will work with HHSC to integrate these programs into the Medicaid managed care program no later than September 1, 2014.

**Texas Resilience and Recovery (TRR)**
TRR is an array of evidence-based services to assist adults and children/adolescents to effectively manage their mental illness and achieve recovery, including community-based services that assist in stabilizing crisis situations, minimize hospitalizations and re-hospitalizations, restore functioning, assist with adherence to medication regimens, promote integration into the larger community, and assist with linkage to other required community-based services.

**Jail Diversion and Continuity of Care Activities for Incarcerated Individuals**
DSHS contracts with local mental health authorities (LMHAs) throughout the state to engage in jail diversion activities as well as activities to enhance continuity of care for incarcerated adults and children/adolescents with a mental illness.

**Community Crises Services**
The 80th and 81st Legislatures appropriated funding to redesign the community mental health crisis system. The desired impact of this redesign initiative is to improve responses to behavioral health crises, including services to prevent hospitalization and restore competency in an outpatient setting.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

The CMHS Program measures effectiveness and efficiency using the following outcome measures.

| Annual Outcome Measures for Adults Served at DSHS-Funded Community Mental Health Centers in Fiscal Years 2011 and 2012 | | |
|---|---|---|
| **Performance Measures** | **FY 2011** | **FY 2012** |
| Average monthly percentage of adults in community mental health services appropriately authorized | 92% | 91% |
| Average monthly percentage receiving minimum number of recommended service hours | 88% | 86% |
| Percentage receiving first service encounter within 14 days of assessment | 80% | 82% |
| Percentage avoiding crisis | 98% | 98% |
| Percentage admitted 3 more times in 180 days to a state or community psychiatric hospital | 0.36% | 0.36% |
| **Annual Outcome Measures** | **FY 2011** | **FY 2012** |
| Percentage of adults in community mental health services with improved or acceptable functioning | 35% | 37% |
| Percentage with improved or acceptable housing | 71% | 74% |

| Annual Outcome Measures | FY 2011 | FY 2012 |
|---|---|---|
| Percentage with improved criminal justice involvement | 53% | 54% |
| Percentage with improved or acceptable co-occurring substance use | 85% | 85% |
| Source: *DSHS Behavioral Health Data Book* | | |

| Annual Outcome Measures for Children Served at DSHS-Funded Community Mental Health Centers in Fiscal Years 2011 and 2012 | | |
|---|---|---|
| **Performance Measures** | **FY 2011** | **FY 2012** |
| Average monthly percentage of children in community mental health services appropriately authorized | 92% | 93% |
| Average monthly percentage receiving minimum number of recommended service hours | 87% | 88% |
| Percentage receiving first service encounter within 14 days of assessment | 77% | 78% |
| Percentage avoiding crisis | 98% | 98% |
| Percentage admitted 3 more times in 180 days to a state or community psychiatric hospital | .04% | .06% |
| **Annual Outcome Measures** | **FY 2011** | **FY 2012** |
| Percentage of children with improved or acceptable problem severity | 41% | 41% |
| Percentage with improved or acceptable co-occurring substance use | 81% | 81% |
| Source: *DSHS Behavioral Health Data Book* | | |

In addition, DSHS has collaborated with the Legislative Budget Board to develop the following measures to show the effectiveness and efficiency of the crisis program:

- number of persons receiving crisis residential services per year funded by new monies;
- number of persons receiving crisis outpatient services per year funded by new monies;
- average amount of new monies per person spent on crisis residential services; and
- average amount of new monies per person spent on crisis outpatient services.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**2003** – The Legislature mandates that the legacy TDMHMR develop and deploy an evidence-based disease management model for adults with SMI, including schizophrenia, bipolar disorder, and major depressive disorder; and for children with SED.

**2005** – DSHS completes rollout of Resiliency and Disease Management (RDM), creating fundamental changes in the type and amount of services delivered to adults with SMI and to

children/adolescents with SED. RDM includes two key elements: a uniform assessment, and an encounter data reporting and warehousing system.

**2007** – The Legislature appropriates $82 million to make significant progress toward improving the response to MHSA crises. The first phase of implementation focuses on ensuring statewide access to competent rapid response services, avoiding hospitalization, and reducing the need for transportation.

**2009** – The Legislature continues funding for crisis services redesign for the 2009-10 biennium.

**2013** – DSHS begins implementing significant changes to RDM. The redesigned program, TRR, is a recovery-oriented system of care that emphasizes fidelity with evidence-based practices. Beginning in fiscal year 2014, MHSA will use new assessment tools that will improve the accuracy of client outcome data.

**2013** – The Legislature appropriates $252 million to advance community-based mental health services through a diverse array of initiatives designed to improve timely access to mental health services in the most appropriate setting. The funding supports education and prevention, expanded treatment capacity and alternatives to hospitalization, housing services, and expansion of the Youth Empowerment Services (YES) Medicaid waiver program for children at risk of parental relinquishment. In addition, new or expanded projects and pilot programs address the needs of special populations, including individuals experiencing mental health and homelessness, adults with complex needs and repeated hospitalizations, veterans, individuals at risk of incarceration, and those in need of competency restoration services.

The Legislature also passes legislation requiring HHSC to integrate physical and behavioral health services into the Medicaid managed care program, including the targeted case management and psychosocial rehabilitative services currently administered by DSHS. HHSC, working in conjunction with DSHS, must complete this integration by September 1, 2014.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

The CMHS Program targets adults with SMI and children with SED. Any adult or child/adolescent who is a member of the DSHS priority population is eligible to receive services.

The adult priority population includes adults with SMI such as schizophrenia, bipolar disorder, major depressive disorder, or other severely disabling mental disorders that require crisis resolution and/or ongoing long-term support and treatment. The program requires that individuals who have incomes above 150 percent federal poverty level pay for services in accordance with a sliding-fee schedule.

| More Texas Adults Estimated to Have Serious and Persistent Mental Illness than DSHS-Funded Community Mental Health Can Treat in Fiscal Years 2011 and 2012 | | | |
|---|---|---|---|
| **Year** | **Estimated Number with Serious and Persistent Mental Illness** | **Number Served at DSHS-Funded Community Mental Health Centers** | **Percent Treated** |
| 2011 | 499,721 | 158,010 | 31.6% |
| 2012 | 496,390 | 155,770 | 31.4% |
| Source: DSHS Community Mental Health Block Grant Narrative, 2007 and 2008, based on methodology specified in *Federal Register* 64, No. 121 (Thursday, June 24, 1999): Notices (33890-33897). | | | |
| Note: Adults with SMI may not necessarily seek treatment, and those who do might do so outside the DSHS-Funded CMHS system. Number and percent served includes NorthSTAR. | | | |

| Percentage Distribution of Primary Diagnoses among Adults Served at DSHS-Funded Community Mental Health Centers in Fiscal Years 2011 and 2012 | | |
|---|---|---|
| **Diagnosis** | **FY 2011** | **FY 2012** |
| Major Depressive Disorder | 34% | 34% |
| Bipolar Disorder | 37% | 36% |
| Schizophrenia | 24% | 25% |
| All Other | 5% | 5% |
| Total | 100% | 100% |
| Source: DSHS Behavioral Health Outpatient Warehouse. | | |
| Note: House Bill 2292, 78th Legislature, Regular Session, 2003, requires DSHS-funded community mental health centers to ensure the provision of disease management practices for adults with bipolar disorder, schizophrenia, or severe depression. | | |

The CMHS Program provides crisis services to all children and families presenting with a mental health crisis; there are no eligibility requirements beyond clinical need. The program provides clinic and community-based services to children ages 3-17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, intellectual disability, autism, or pervasive development disorder) who exhibit serious emotional, behavioral, or mental disorders and who:

- have a serious functional impairment;
- are at risk of disruption of a preferred living or childcare environment due to psychiatric symptoms; or
- are enrolled in a school system's special education program because of an SED.

| More Texas Children Estimated to Have Serious Emotional Disturbance than DSHS-Funded Community Mental Health Can Treat in Fiscal Years 2011 and 2012 | | | |
|---|---|---|---|
| **Year** | **Estimated Number with Serious Emotional Disturbance** | **Number Served at DSHS-Funded Community Mental Health Centers** | **Percent Treated** |
| 2011 | 156,390 | 46,463 | 29.7% |
| 2012 | 175,937 | 47,034 | 26.7% |
| Source: DSHS Community Mental Health Block Grant Narrative, 2007 and 2008, based on methodology specified in *Federal Register,* Volume 64, Number 121, Thursday, June 24, 1999, Notices, pp. 33890-33897. | | | |
| Note: Children with SED and their families may not necessarily seek treatment, and those who do might do so outside the DSHS-Funded CMHS system. Number and percent served includes NorthSTAR. | | | |

| Percentage Distribution of Primary Diagnoses among Children Served at DSHS-Funded Community Mental Health Centers in Fiscal Years 2011 and 2012 | | |
|---|---|---|
| **Diagnosis** | **FY 2011** | **FY 2012** |
| Attention Deficit Disorder | 47% | 48% |
| Disruptive Behavior Disorder | 13% | 13% |
| Bipolar Disorder | 7% | 6% |
| Major Depressive Disorder | 7% | 7% |
| Other Affective Disorders | 11% | 11% |
| Other Non-Psychotic Disorders | 9% | 9% |
| All Other | 6% | 6% |
| **Total** | **100%** | **100%** |
| Source: Consumer Analysis Data Warehouse. | | |

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The MHSA Division, Program Services Section and Contract Services Section administer CMHS. Within the two sections, the following units specifically administer the community mental health program:

- Program Services Section, Adult Mental Health Services Unit,
- Program Services Section, Child and Adolescent Services,
- Program Services Section, Disaster Behavioral Branch,
- Contract Services Section, Mental Health Contracts Unit, and
- Contract Services Section, Quality Management Unit.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/mhsa.shtm.

LMHAs and their local provider networks currently provide mental health services for adults and children. LMHAs directly contract with DSHS for the provision of mental health services in 37 local service areas across the state. A licensed health maintenance organization administers mental health services provided to individuals residing in the seven-county NorthSTAR region. Currently, these are the only providers in Texas who meet the state eligibility requirements to provide Medicaid targeted case management and psychosocial rehabilitative services.

DSHS staff is currently responsible for promulgating rules and policies and, in conjunction with HHSC, developing any required Medicaid waivers or Medicaid state plan amendments pertaining to Medicaid-funded mental health services. DSHS staff also works closely with HHSC to identify the potential effects of changes to Medicaid policy on mental health services prior to implementation of the policy. In 2014, HHSC will administer Medicaid-funded mental health services outside the NorthSTAR service area through the Medicaid managed care program. DSHS will retain full responsibility for services provided to medically indigent children and adults.

DSHS oversees the quality of services provided to consumers and administers sanctions and other contract penalties as required. To help ensure the quality of services and compliance with state and federal regulations, DSHS provides both training and technical assistance to LMHAs on a regular basis.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $104,969,044 |
| General Revenue | $334,823,874 |
| General Revenue-Dedicated | 0 |
| Other | $2,295,946 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| NorthSTAR Program | Both the CMHS and the NorthSTAR programs provide an array of evidence-based | NorthSTAR is a managed care behavioral health “carve out” that operates under a Medicaid 1915(b) |

| Name | Similarities | Differences |
|---|---|---|
| | services to adults with SMI. Both serve Medicaid-eligible, as well as uninsured (medically indigent) individuals. Both fund community hospital-based services and provide mental health services under the TRR model. | waiver in seven Texas counties. NorthSTAR provides certain mental health services to Medicaid-eligible individuals residing in the designated seven-county area who are not members of the DSHS adult mental health priority population. |

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) – Adult | TCOOMMI and CMHS both provide an array of services to adults with mental illness. TCOOMMI programs provide case management; rehabilitation and psychological services; psychiatric services; medication and monitoring; individual and group therapy; skills training; benefit eligibility services; screening and linkage to appropriate medical services, including hospice; jail screening; court intervention; and pre-release referral process for jails and families. | TCOOMMI serves offenders with mental illness in the criminal justice system. DSHS programs serve persons with mental illness in the general community. DSHS provides services to a narrowly defined target population, while TCOOMMI serves persons with a wider spectrum of mental disorders. |
| TCOOMMI – Youth | TCOOMMI and CMHS both provide an array of services to youth with mental illness. Services include assessments for service referral; service coordination and planning; medication and monitoring; individual and/or group therapy and skills training; in-home services such as family therapy; family-focused support services; benefit eligibility services; advocacy; and transitional services. | TCOOMMI serves juvenile offenders with behavioral and emotional disturbance. DSHS programs serve children and adolescents with SED in the general community. DSHS provides services to a defined priority population while TCOOMMI serves youth with a wider spectrum of mental disorders. |

| Name | Similarities | Differences |
|---|---|---|
| Department of Aging and Rehabilitative Services, Early Childhood Intervention (ECI) | ECI services are similar to those provided by CMHS and include screening and assessment, family counseling, family education, psychological services, service coordination, and social work services. | ECI provides evaluations, at no cost to families, to determine eligibility and the need for services for children ages 0-3 with developmental delays, atypical development, atypical sensory-motor development, atypical language or cognition, atypical emotional or social patterns, and/or a specific medically diagnosed conditions.<br><br>CMHS provides mental health services to children and adolescents ages 3-17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, intellectual disability, autism, or pervasive development disorder). Consumers must exhibit serious emotional, behavioral, or mental disorder and: (a) have a serious functional impairment; or (b) be at risk of disruption of a preferred living or childcare environment due to psychiatric symptoms; or (c) be enrolled in a school system's special education program because of serious emotional disturbance. |
| Department of Family and Protective Services, Child Protective Services | Child Protective Services ensures the provision of mental health services to children within state custody. | Child Protective Services serves as the conservator for children within the foster care system and ensures appropriate medical care, including mental health services. Every child in foster care can receive physical and behavioral healthcare services that include dental services, vision services, service coordination, clinical services, disease management, and Health Passport. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

The NorthSTAR Program, operated by DSHS, serves individuals who reside in seven Texas counties (Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall). Providers in the local networks within the NorthSTAR area serve individuals in the NorthSTAR system. The DSHS Client Assignment and Registration System captures county of residence for each consumer, which prevents duplication of assignment between local service regions. However, if an individual from within the NorthSTAR area is in a different part of the state when experiencing a mental health crisis, that individual may receive services through the LMHA serving that region. In such instances, the LMHA providing the crisis service may bill NorthSTAR for the crisis services.

TCOOMMI and DSHS have a collaborative relationship, formalized through a memorandum of understanding, which promotes effective treatment for those served in both systems. In order to enhance the coordination of services, minimize conflict, and reduce the potential for service duplication, DSHS is a standing member of the TCOOMMI Interagency Advisory Committee that meets on a quarterly basis. This approach ensures that the two agencies work together to resolve issues that may arise, identify opportunities for coordination, and ensure a seamless service experience for the individuals served by each respective agency.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Community Mental Health Centers (CMHCs) | CMHCs are vital components in a continuum of services for persons with mental illness. By statute, a CMHC is:<br>• an agency of the state, a governmental unit, and a unit of local government, as defined and specified by Chapters 101 and 102, Texas Civil Practice and Remedies Code;<br>• a local government, as defined by § 791.003, Texas | DSHS has designated 37 CMHCs to serve as LMHAs for local service areas statewide. In their role as local authorities, the CMHCs:<br>• consider and assess public input, ultimate cost-benefit, and client care issues to ensure individual choice and the best use of public funding in assembling a network of service providers; and<br>• make recommendations relating to the most appropriate and available treatment outcomes, while |

| Name | Description | Relationship to DSHS |
|---|---|---|
| | Government Code;<br>• a local government for the purposes of Chapter 2259, Texas Government Code; and<br>• a political subdivision for the purposes of Chapter 172, Texas Local Government Code. | allowing flexibility to maximize local resources. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Centers for Medicare & Medicaid Services (CMS) | CMS is an agency of the U.S. Department of Health and Human Services (DHHS) that oversees both the Medicare and Medicaid programs. | HHSC designated DSHS as a Medicaid operating agency for certain programs. DSHS operates two Medicaid community-based programs that fund services for adults with SMI. DSHS contracts with qualified entities to provide Mental Health Rehabilitative Services and Targeted Case Management to the DSHS adult priority population. DSHS monitors providers to ensure compliance with federal and state regulations governing these two programs. DSHS also works collaboratively with HHSC to maximize Medicaid funding and to make changes as necessary to the Medicaid state plan to ensure maximum clinical effectiveness of services. |
| Substance Abuse Mental Health Services Administration (SAMHSA), Center for Mental Health Services | SAMHSA, an agency of the DHHS, focuses attention, programs, and funding on improving the lives of individuals with, or at risk for, mental and substance use disorders. The Center for Mental Health Services is the specific entity that focuses on oversight, training, and technical assistance to the states for mental health. | SAMHSA provides funding to DSHS by way of the formula-driven Mental Health Block Grant, which funds a range of services for adults with SMI. SAMHSA has also awarded a grant to DSHS designed to assist states in transforming their mental health service systems to create an effective, transparent, and easily navigable system. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts in this program for the following:

- consumer-operated services;
- operation of community mental health hospitals;
- reduction of waiting list for community mental health services for children;
- demonstration projects to maintain independence and employment;
- Money Follows the Person pilot;
- mental health deputies in selected counties;
- statewide training for mental health service providers;
- updates and improvements to mental health service delivery;
- outpatient competency restoration;
- mental health services to aid in transition from homelessness;
- performance contract notebook;
- psychiatric emergency service centers;
- provision of psychiatrists to serve uninsured clients;
- mental health disaster response services;
- transition from nursing homes to community settings;
- oversight of residential transition services;
- emergency disaster relief for hurricane response;
- trainers for suicide prevention, trauma, disaster response, and psychological first aid;
- expansion of services and supports for children and adolescents with SED;
- mental health services for veterans and their families;
- youth suicide prevention services and project evaluation;
- internship program for workforce development; and
- special provider training.

Amount of contracted expenditures in fiscal year 2012: $329,122,684
Number of program contracts: 237 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $49,702,446 | MHMR Harris County | Mental health services through LMHA |
| $28,493,696 | MHMR Harris County | Operation of community mental health hospital |
| $22,199,094 | MHMR Tarrant County | Mental health services through LMHA |
| $19,752,509 | Center for Health Care Services | Mental health services through LMHA |
| $15,000,000 | Montgomery County | Adult inpatient mental health services |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

The program awards grants for the following services:

- consumer-operated services;
- operation of community mental health hospitals;
- reduction of waiting list for community mental health services for children;
- demonstration projects to maintain independence and employment;
- Money Follows the Person pilot;
- mental health deputies in selected counties;
- statewide training for mental health service providers;
- updates and improvements to mental health service delivery;
- outpatient competency restoration;
- mental health services to aid in transition from homelessness;
- psychiatric emergency service centers;
- psychiatrists to serve uninsured clients;
- mental health disaster response services;
- transition from nursing homes to community settings;
- oversight of residential transition services;

- emergency disaster relief for hurricane response;
- trainers for suicide prevention, trauma, disaster response, and psychological first aid;
- expansion of services and supports for children and adolescents with SED;
- mental health services for veterans and their families;
- youth suicide prevention services and project evaluation;
- internship program for workforce development; and
- special provider training.

Using sub-recipient contracts, the program awards grants in the following manner:

- through competitive solicitations;
- on an emergency or sole source basis when an approved emergency or sole source justification waives competition;
- by direct negotiation and grant contract execution to a state or local governmental entity, since these entities are exempt from competition; and
- through a specific legislative mandate that requires DSHS to directly negotiate and execute a grant contract with a prescribed entity or entities (Section 533.034, Texas Health and Safety Code, Authority to Contract for Community-Based Services).

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory changes to assist the program in performing its functions.

**Chapter 577, Texas Health and Safety Code** – This statute sets forth the requirements for psychiatric hospital licensure and crisis stabilization units. Additionally, Chapter 448, Texas Health and Safety Code sets forth substance abuse licensure parameters. DSHS has identified the need for new licensure types; however, the agency does not have the authority to do so under current statute. As the SMHA and State Substance Abuse Authority, DSHS sets operational and clinical policy for a variety of community-based and facility-based behavioral health services. To ensure appropriate and cost effective treatment, DSHS believes that licensure types need to evolve as services and evidence-based practices evolve. In some instances, the current limit of two mental health facility licensure types leads to operational issues.

**Chapter 574, Texas Health and Safety Code and Article 46B Code of Criminal Procedure** – DSHS recommends expanding the allowable circumstances for court-ordered medication for patients in jail determined incompetent to stand trial. Some patients considered for outpatient competency restoration could benefit from court-ordered medications when refusing to take medication. Currently the statute requires that they lack the capacity to make the decision to take medication and are in imminent risk of harming themselves or others before a judge can court-order medication.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Substance Abuse Prevention, Intervention, and Treatment |
| **Location/Division** | 909 West 45th Street, Austin – Mental Health and Substance Abuse (MHSA) Services Division |
| **Contact Name** | Mike Maples, Assistant Commissioner, MHSA Services Division |
| **Actual Expenditures, FY 2012** | $138,571,360 |
| **Number of Actual FTEs as of June 1, 2013** | 83.1 |
| **Statutory Citation for Program** | Chapters 461-469, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

The Substance Abuse Prevention, Intervention, and Treatment (SAPIT) Program has as its primary objective to provide supports and services for substance abuse prevention, intervention, and treatment. Major activities include the following.

**State Substance Abuse (SSA) Authority Activities**

The Assistant Commissioner of the MHSA Services Division serves as the SSA in Texas for substance abuse prevention, intervention, and treatment services, including tobacco cessation services. The MHSA Services Division designs and implements policy relating to substance abuse services and serves as a Medicaid operating division under HHSC. DSHS provides substance abuse services to eligible adults and youth/adolescents. The agency contracts with treatment providers for services for priority populations. The division develops rules relating to the delivery of substance abuse services and defines optimal outcomes for services. Additionally, the division provides technical assistance and training to contracted providers, monitors compliance, and issues findings when needed.

**Substance Abuse Prevention**

Substance abuse prevention activities improve lives by discouraging substance use before it results in costly and life-threatening consequences, such as emergency room visits and drunken driving fatalities. These services affect three different groups: the entire population, without regard to individual risk factors; subgroups of the general population determined to be at risk for substance abuse; and individuals experimenting with substances and exhibiting problem behaviors associated with substance abuse. Providers of prevention services deliver evidence-based curricula recognized by the National Registry of Evidence-based Programs and Practices

and implement in schools and community sites the six effective strategies of the Center for Substance Abuse Prevention.

**Substance Abuse Intervention**

Substance abuse intervention services include outreach, screening, assessment, and referral (OSAR). This program refers potential clients for treatment and other appropriate services. Service providers assist with movement of block grant priority populations through the continuum of care, including the link between treatment and community-based support services. Additional intervention services include Pregnant Postpartum Intervention, Human Immunodeficiency Virus (HIV) Early Intervention, and Rural Border Intervention.

**Substance Abuse Treatment**

Substance abuse treatment activities address the client's psychosocial and familial needs along with treating the substance abuse or dependency. Treatment approaches are research-based, holistic in design, and emphasize coordination of care across the continuum. Service modalities meet client needs and preferences, and they vary in intensity. These services include residential and ambulatory detoxification (for adults), intensive and supportive residential care, opiate replacement therapy, and outpatient programs. Within each of these services, program activities include family, group, and individual counseling, as well as educational presentations and other support services. Adolescent services also include in-home and school-based counseling when appropriate, and psychiatric consultation if deemed necessary via an assessment and/or interview.

**Recovery Support Services**

In fiscal year 2014, DSHS will be piloting and contracting for the development of recovery support services with both recovery community organizations and facilitating organizations, which are treatment providers. These services will support individuals in continuing their recovery, once they transition from treatment back into the community.

**Tobacco Prevention and Control**

The Tobacco Prevention and Control Program is charged with reducing the impact of tobacco and tobacco-related health problems on the citizens of Texas. The program uses a multi-pronged approach that focuses on prevention of tobacco initiation, supporting cessation efforts, eliminating tobacco-related health disparities, supporting efforts to reduce youth access to tobacco, and maintaining the infrastructure throughout the state to carry out these goals. Specific activities include funding and developing local coalitions to address local tobacco issues, funding a statewide telephone counseling initiative for tobacco cessation, utilizing media to support program goals, changing tobacco norms through policy and environmental changes, implementing best practices and evidence-based approaches at the local and state levels, and utilizing appropriate surveillance and evaluation methods to measure program outcomes. The program carries out this mission through a network of state, regional, and local partnerships and collaborations.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

**Substance Abuse Prevention**

Substance Abuse Prevention measures effectiveness and efficiency using the following measures.

| Performance Measures | FY 2012 |
|---|---|
| Number of youth receiving prevention education through evidence-based curricula | 198,046 |
| Number of youth successfully referred to treatment or other support services | 35,939 |
| Number of youth involved in alcohol and other drugs alternative activities | 354,860 |
| Number of youth involved in tobacco alternative activities | 385,065 |

**Substance Abuse Intervention**

Substance Abuse Intervention measures effectiveness and efficiency using the following measures.

| Performance Measures | FY 2012 |
|---|---|
| Number of adults identified as having a problem or being at risk for HIV | 56,989 |
| Number of adults admitted or referred for substance abuse treatment as a result of HIV outreach effort | 2,091 |
| Number of adults tested for HIV infection through HIV outreach efforts | 15,123 |
| Number of pregnant postpartum adults screened for substance abuse risk factors | 2,339 |
| Number of adult Pregnant Postpartum Intervention (PPI) participants receiving education and skills training | 1,612 |
| Number of youth screened for substance abuse | 2,137 |
| Number of youth receiving education/skills training | 2,743 |

**Substance Abuse Treatment**

Substance Abuse Treatment measures effectiveness and efficiency using the following measures.

| Performance Measures | FY 2012 |
|---|---|
| Number served | 49,001 |
| Percent who successfully complete services | 89% |
| Percent abstinent at discharge | 56% |
| Percent discharged to stable housing | 89% |
| Percent with no arrest since admission | 96% |
| Percent employed or attending school or vocational training at discharge | 38% |
| Percent engaged in social support activities at discharge | 78% |

**Tobacco Prevention and Control**
Tobacco Prevention and Control uses selected goals established by the Centers for Disease Control and Prevention (CDC) National Tobacco Control Program to measure the reduction in smoking rates in Texas.

| Measure | Data Source | Baseline |
|---|---|---|
| Illegal tobacco sales to minors | Synar Inspection Survey | 56% |
| Decline in youth tobacco use ($6^{th}$-$12^{th}$ grades) | Youth Tobacco Survey | 34% |
| Decline in adult smoking rates | Behavioral Risk Factor Surveillance Survey | 23.7 % |
| Decline in the percentage of youth ($6^{th}$-$12^{th}$ grades) who are exposed to secondhand smoke in homes and cars | Youth Tobacco Survey | 68% |
| Texas middle and high school students ($7^{th}$-$12^{th}$ grades) who used tobacco during past month | Texas School Survey of Substance Abuse | 23% |

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1995** – The Substance Abuse and Mental Health Services Administration (SAMHSA) mandates that all single state substance abuse agencies with high seroprevalence rates (the 10 states with highest level of HIV infection) set aside as much as five percent of their annual Center for Substance Abuse Treatment Block Grant award to fund HIV program activities that target injecting drug users and other substance abusers for their states.

**1998** – The pregnant postpartum federal demonstration program for females begins to receive funding throughout the state.

**2001** – The Legislature establishes the Drug Demand Reduction Advisory Committee with a mandate to develop and coordinate a statewide strategy to reduce drug demand in Texas.

**2002** – The legacy Texas Commission on Alcohol and Drug Abuse develops the Behavioral Health Integrated Provider System (BHIPS), a web-based system to support a comprehensive service delivery system for substance abuse providers.

**2003** – Prevention providers begin implementing approved evidence-based programs from the National Registry of Evidence-based Programs and Practices.

**2004** – DSHS releases the first comprehensive five-year cycle request for proposal (RFP) for substance abuse prevention, intervention, and treatment services. DSHS also initiates rural border intervention programs.

**2007** – The statewide Tobacco Prevention and Control Program moves from the Prevention and Preparedness Division to the MHSA Services Division to align better with DSHS efforts to coordinate and streamline programming, allocation of resources, and collaboration with public and private partners. The result is a consolidation of services into one division.

**2008** – DSHS releases the fiscal year 2009 behavioral health prevention and intervention services RFP for the procurement of services. DSHS also implements the evidence-based Cannabis Youth Treatment Model in youth outpatient programs.

**2010** – DSHS adds buprenorphine medication to all opiate replacement programs' contracts, following a successful pilot that began in 2007.

**2010** – DSHS implements a Medicaid benefit for substance abuse. In addition, the agency implements statewide the upgraded and more comprehensive electronic record system, Clinical Management for Behavioral Health Services (CMBHS), in substance abuse programs, replacing BHIPS.

**2011** – DSHS initiates tobacco cessation services. The agency also implements the development of a Recovery Oriented System of Care statewide, which focuses on integration recovery concepts and collaboration in local communities.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

**Substance Abuse Prevention**

Substance abuse prevention strategies target at-risk and high-risk youth and their families, as well as the public. DSHS delivers services based on these strategies through school and community-based programs. In fiscal year 2012, prevention programs served 2,687,988 individuals. In fiscal year 2012, the curricula-based substance abuse program served 236,716 individuals (51 percent male and 49 percent female; 96 percent children and 4 percent adults; 52 percent Hispanic, 18 percent White, 17 percent Black, and 13 percent other).

**Substance Abuse Intervention**

In fiscal year 2012, substance abuse intervention programs served 269,847 persons. The target populations for each substance abuse intervention service are as follows.

- The HIV Outreach and Early Intervention Program targets persons at risk of infection from HIV, as a result of behavior associated with substance abuse or those testing HIV+ with

history of substance abuse. In fiscal year 2012, HIV Outreach served 80,545 individuals (62 percent male and 38 percent female; 37 percent Hispanic, 36 percent Black, 18 percent White, and 9 percent other). HIV Early Intervention served 35,917 individuals (68 percent male and 32 percent female; 36 percent Black, 28 percent Hispanic, 19 percent White, and 17 percent other).

- The Rural Border Initiative targets members of communities in health service regions (HSRs) within 62 miles north of the Texas-Mexico border. Services focus on high-risk youth and adults and their families and significant others. In addition, services build community coalitions and resources. In fiscal year 2012, the program served 1,176 individuals in (60 percent female and 40 percent male; 73 percent children and 27 percent adults; 94 percent Hispanic and 6 percent other).
- OSAR activities affect persons with chemical dependency issues whose incomes are at or below 200 percent federal poverty level (FPL). In fiscal year 2012, the program screened 20,187 persons for substance abuse disorders (55 percent male and 45 percent female; 49 percent White, 36 percent Hispanic, 14 percent Black, and 1 percent other.)
- Pregnant Postpartum Intervention (PPI) targets adult and adolescent pregnant and postpartum women at risk for substance abuse due to Child Protective Services involvement; poverty; teen pregnancy; domestic violence; current or past history of sexual, emotional or physical abuse; mental health problems and substance use; or residency with a substance using or abusing person. In fiscal year 2012, PPI programs served 1,993 females (76 percent 18 years and older, 24 percent under 18 years; 55 percent Hispanic, 26 percent Black, 26 percent White, and 3 percent other)

**Substance Abuse Treatment**

Substance abuse treatment affects all persons with substance use disorders who are at or under 200 percent FPL. In fiscal year 2012, treatment programs served 49,001 individuals (61 percent male and 39 percent female; 88 percent adults and 12 percent children; 43 percent White, 34 percent Hispanic, 18 percent Black, and 5 percent other).

**Tobacco Prevention and Control**

Tobacco prevention and control activities affect all Texans. The program targets for "prevention of initiation" those who do not use tobacco and targets for cessation those who use tobacco. The program targets all Texans regarding the harmful effects of secondhand smoke. There are no eligibility requirements. In fiscal year 2012, the comprehensive tobacco prevention and control coalition target communities served 3.1 million individuals. In fiscal year 2012, the comprehensive tobacco prevention and control coalition target communities served 3.1 million people. One component of the tobacco program, the Quitline, had 25, 176 calls (approximately 62 percent female and 38 percent male; 59 percent White, 21 percent Black, 17 percent Hispanic, and 3 percent other).

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

For all SAPIT Program activities, DSHS staff provides policy and program expertise, develops administrative rules, and provides technical assistance and program guidance to the funded providers. DSHS staff also manages the programmatic aspects of the evidence-based treatment programs to ensure that best practices are in place. DSHS oversees the quality of services provided to adults and youth with substance use disorders and administers sanctions and other contract penalties as required. To help ensure the quality of services and compliance with state and federal regulations, DSHS provides both training and technical assistance to contractors on a regular basis.

**Substance Abuse Prevention**

The MHSA Services Division, Program Services Section, Child and Adolescent Services Section and the Substance Abuse Contract Services Section administer substance abuse prevention activities and contracts. Nonprofit, community-based organizations deliver substance abuse prevention services to youth and their families through regional contracts. Currently, 193 funded prevention programs deliver direct services to the universal, selective, and indicated populations in school districts and community centers. In addition, 11 regional Prevention Resource Centers (PRCs) serve as clearinghouses in HSRs to disseminate information to local communities and provide merchant education on the tobacco laws. Twenty-three non-direct community coalitions mobilize key stakeholders in policy change within their communities. Beginning in fiscal year 2014, the number of programs funded in these different service categories will change to coincide with the recommendations of the Statewide Prevention Plan. Additionally, the PRCs will change their scope from information clearinghouses to regional data repositories. They will collaborate with coalitions, universities, hospitals, substance abuse treatment centers, and LMHAs in their regions on local and regional data.

DSHS also conducts the Texas School Survey of Substance Use Among Students (elementary and secondary students). This survey allows DSHS to analyze the trends of use across the state. The survey collects data on patterns of use, experimentation, knowledge, and attitudes to provide the most current information on consumption of alcohol, tobacco, and other drugs.

**Substance Abuse Intervention**

The MHSA Services Division, Program Services Section, Substance Abuse Services Unit and the MHSA Services Division, Contract Services Section, Substance Abuse Contracts Unit administer substance abuse intervention activities. Fifty-seven local and/or regional service providers contract with DSHS to provide these services.

**Substance Abuse Treatment**

The MHSA Services Division, Program Services Section, Substance Abuse Services Unit and the MHSA Services Division, Contract Services Section, Substance Abuse Contracts Unit administer substance abuse treatment activities. Currently, DSHS contracts with approximately 141 licensed treatment programs across the state and NorthSTAR to provide adult and youth treatment services. In HSR 4/5, the South East Texas Regional Planning Commission contracts directly with DSHS and then sub-contracts with local licensed providers in the area to provide substance abuse treatment services. DSHS distributes funds in all HSRs based on population, need, and geographic area.

**Tobacco Prevention and Control**

The MHSA Services Division, Program Services Section, Substance Abuse Services Unit, Tobacco Prevention and Control Team and the MHSA Services Division, Contracts Services Section, Substance Abuse Contracts Unit administer tobacco prevention and control activities. DSHS contracts with local, regional, and state partners to conduct tobacco prevention and control activities. Partners include schools, colleges, local health departments and health districts, statewide organizations, and private businesses.

The Tobacco Prevention and Control Program focuses on two primary community efforts.

- The program conducts comprehensive efforts in six target communities across the state using community mobilization, community/school prevention, youth and adult cessation, media, enforcement, and enhanced evaluation. In the remainder of the state, regional staff, working through local coalitions and stakeholders, focuses efforts on developing environmental policy changes (such as smoke-free worksites and municipal smoke-free ordinances) that can impact a large segment of the community by creating healthier environments for nonsmokers and smokers alike, and promoting a supportive environment for former smokers. Regional PRCs and substance abuse prevention providers conduct tobacco-prevention awareness activities and retailer education. The Texas Education Agency, through an interagency agreement with DSHS, provides tobacco prevention education in grades 4-12 across the state.
- The Comptroller of Public Accounts carries out enforcement activities throughout the year, spending approximately $2.2 million on activities such as retailer/public education, compliance inspections, and follow-up. DSHS conducts the annual inspection survey of retailer compliance to meet federal requirements; substance abuse prevention providers conduct retailer education and tobacco prevention awareness strategies for youth and adults on the Texas tobacco laws. SAP provides the Texas Youth Tobacco Awareness Program aimed at youth cited for violation as a minor in possession of tobacco.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/mhsa.shtm

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $109,209,345 |
| General Revenue | $23,084,886 |
| General Revenue-Dedicated | $5,301,335 |
| Other | $975,794 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| Disease Control and Prevention (DCP) Services Division, HIV - Sexually Transmitted Diseases (STD) Comprehensive Services and Epidemiology and Surveillance Branches | The DCP Services Division programs provide HIV testing, counseling, and case management to HIV-infected persons. | The MHSA Services Division programs focus on substance using and abusing populations and their partners or significant others. MHSA does not provide medical care/services. |
| Family and Community Health Services (FCHS) Division, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | Both WIC and PPI programs work with pregnant and parenting women. Both programs administer a risk assessment to identify substance abuse, mental health, and related problems. | WIC is available during pregnancy and until the child is three years of age. DSHS provides PPI services during pregnancy and up until the child is 18 months of age. WIC is also available to all financially eligible women; in contrast, PPI programs target an at-risk population due to specific behavioral health factors. WIC is a nutrition program while the PPI programs are social service and case management entities. |

| Name | Similarities | Differences |
|---|---|---|
| FCHS Division, Maternal and Child Health (MCH) Programs | Both PPI and MCH programs serve pregnant and parenting women. | MCH programs are primarily for medical care; PPI programs provide social services for behavioral health concerns. |
| NorthSTAR Program | Both NorthSTAR and MHSA Services Division substance abuse programs provide treatment services to adults and youth with chemical dependency problems. | NorthSTAR is a fully capitated managed care behavioral health "carve out" that operates under a Medicaid 1915(b) waiver in only seven Texas counties in the Dallas area. NorthSTAR uses a blended funding approach to provide substance abuse services as well as a broader array of Medicaid-funded services |
| DCP Services Division, Chronic Disease Prevention Program | Both the Chronic Disease Prevention Program and the Tobacco Prevention and Control Program focus on risk factors that lead to cardiovascular disease, diabetes, cancer, and other chronic health issues. Both coordinate with stakeholders, such as American Cancer Society on tobacco issues. | Tobacco is a risk factor for multiple chronic diseases. While the Chronic Disease Prevention Program focuses on many risk factors, the Tobacco Prevention and Control Program targets only tobacco. |

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Federally Qualified Health Centers (FQHCs) | FQHCs provide primary health care to qualifying individuals. | DSHS has contracts with several FQHCs to provide behavioral health services together with physical health. |
| Texas Academy of Family Physicians (TAFP) | TAFP conducts a tobacco-use prevention initiative (Tar Wars) for elementary students. | TAFP provides the Tar Wars prevention initiative at a limited number of schools. |
| Texas Office on the Prevention of Developmental Disabilities (TOPDD) Fetal Alcohol Syndrome | The FASD Task Force addresses the use of alcohol during pregnancy. The TOPDD activities focus on prevention of alcohol-related birth | PPI programs address the use of alcohol, tobacco, and other drugs during pregnancy. PPI programs target specific high-risk women and provide services |

| Name | Similarities | Differences |
|---|---|---|
| Disorder (FASD) Task Force | defects only. | at a range of community sites. TOPDD activities are constrained by funding considerations and access to the population. |
| Texas Department of Family and Protective Services, Child Protective Services | PPI is a community-based intervention program. Child Protective Services provides some prevention and home-based services. | PPI programs are open to women with several risk factors of which child abuse and neglect is only one. Child Protective Services prevention, home-based safety, and foster care services are for families with child abuse and neglect problems. |
| Texas Department of Criminal Justice (TDCJ), Treatment Alternatives to Incarceration Program (TAIP) | TDCJ contracts with substance abuse programs to provide treatment to selected nonviolent offenders who have committed a substance abuse-related crime and are in jail because of the crime. The individual must complete prescribed treatment to avoid incarceration. | The criminal justice system largely determines the length of the client stays in treatment for TAIP. In the DSHS system, client problem severity and OSAR clinical oversight determine length of stay. |
| Ryan White CARE Act, Title 1 | The Ryan White CARE Act provides medical services for treatment of HIV. | HIV Early Intervention provides medical services only as a stopgap until consumers link to other resources and only as resources allow. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

DSHS has memorandums of understanding (MOUs) with the 16 state agencies that are participating with the Drug Demand Reduction Advisory Committee. Several of these agencies participate in agency initiatives and leverage resources to accomplish targeted goals for various projects.

The prevention programs funded by the SAMHSA Center for Substance Abuse Treatment (CSAT) serve only those individuals at risk of HIV as a result of use or abuse of drugs and alcohol.

However, contract requirements include partnering with those providers with funds from other resources to ensure that consumers of DSHS contractors also have access to services from other providers. This requirement is crucial, since, for example, Ryan White CARE Act recipient organizations have the funding to deliver the clinical services needed to interrupt HIV disease progression. The SAMHSA Outreach and HIV Early Intervention (HEI) Program partners with agencies receiving CDC or Ryan White funds to enhance benefits or strength the continuum of care afforded to eligible clients. When such occasions arise, both programs know to apportion their numbers according to effort and ability, so that there is no duplication. HEI programs could not maintain case management program structure and deliver a full continuum of services without the necessary linkage to Ryan White clinical services. Ryan White programs could not provide clinical care to HIV substance abuse recovery populations without the support of HEI case management.

The PPI programs are required to maintain MOUs with perinatal sites, WIC Program, MCH Programs, Child Protective Services, and other agency sites where pregnant and postpartum women receive social or medical services. PPI services complement services provided by these other programs.

The NorthSTAR Program, operated by DSHS, serves individuals who reside in seven Texas counties (Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall). Providers in the local networks within the NorthSTAR area serve individuals in the NorthSTAR system. The DSHS Client Assignment and Registration System captures county of residence for each consumer, which prevents duplication of assignment between local service regions.

DSHS has a MOU with TDCJ to use specific funds for the Treatment Alternatives to Incarceration Program. The TDCJ Community Justice and Assistance Division coordinates the funding, and the criminal justice system delivers the services.

Programs within the MHSA Services Division and the DCP Services Division are involved in tobacco prevention efforts. Staff stays in continuous contact and communication with counterparts in the other division to avoid duplication of efforts and to identify areas where synergistic collaboration can provide a greater outcome than individual programs working alone.

The MHSA Tobacco Prevention and Control Program coordinates with TAFP to co-sponsor the Tar Wars tobacco prevention activities through local substance abuse providers, the tobacco coalitions, and Comptroller-funded school-based law enforcement grantees. The tobacco program has an interagency contract with the Texas Education Agency to provide tobacco prevention education to students in 4$^{th}$ to 8$^{th}$ grade across the state. The Comptroller of Public Accounts provides funds to the tobacco program through an interagency contract to coordinate prevention activities aimed at reducing minors' access to tobacco products.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| LHDs and districts | LHDs provide general information about communicable disease, screening for tuberculosis and sexually transmitted diseases, and funding for comprehensive tobacco prevention and control coalition activities. | LHDs often receive referrals from local substance abuse treatment programs for screening services on partners of substance abusing individuals. DSHS has a contractual relationship with several LHDs for implementation of tobacco prevention and control strategies through a community coalition. |
| Community mental health centers | Community mental health centers provide outpatient care for clients with major mental illnesses. | DSHS has contracts for substance abuse treatment services (including OSAR) at several community mental health centers around the state. |

**Regional Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Southeast Texas Regional Planning Commission | The Southeast Texas Regional Planning Commission is a local council of government in HSR 5. | The Planning Commission acts as an OSAR site and provides administrative oversight in HSR 5 for substance abuse treatment services. |
| Education service centers | Education service centers provide support for local schools and coordinate school health activities through material dissemination, training, technical assistance, and links to resources. | Education service centers coordinate services to the schools and school districts from the DSHS-funded PRCs regarding regional training and educational materials. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Texas National Guard Drug Demand Reduction Program | The Guard's program provides training and technical assistance to community groups and sponsors and operates a | The program supports local drug prevention organizations with materials, equipment, and personnel. The Guard provides a |

| Name | Description | Relationship to DSHS |
|---|---|---|
| | residential program to remove high-risk teens from the availability of illegal substances. | staff member to coordinate activities with DSHS. |
| White House Office of Drug Control Policy | This office informs the National Prevention Network on national youth and parent campaigns for states. | The office is a source of information for DSHS on substance abuse policy and prevention and treatment strategies. |
| CDC | CDC provides prevention services and monitors HIV surveillance. CDC also provides funds for tobacco prevention and control through a cooperative agreement. In 2012, CDC began to focus on reducing prescription drug abuse and supporting states in the effort. | CDC is a funding source for comprehensive tobacco prevention and control strategies. CDC directs counseling and testing and offers guidelines on screening and testing procedures. |
| SAMHSA | SAMHSA is a section of U.S. Department of Health and Human Services that provides money for prevention and treatment services in the form of the Substance Abuse Prevention and Treatment block grant and other competitive grants. | The MHSA Services Division is the recipient and manager of the block grant dollars for purchasing substance abuse prevention and treatment services. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts in this program for the following:

- community coalition partnerships to reduce substance abuse;
- capacity increase for co-occurring psychiatric and substance abuse disorders treatment;

- interpreter services for clients seeking drug treatment;
- early intervention and outreach HIV services for persons with substance use disorders;
- counseling skills training for providers serving clients at risk for communicable diseases;
- behavioral health managed care pilot;
- substance abuse outreach, screening, assessment, and referral services;
- drug and tobacco prevention and intervention for pregnant women;
- drug and tobacco prevention education;
- substance abuse prevention training for youth and adults;
- substance abuse intervention for rural border counties;
- substance abuse prevention incentives;
- school surveys related to substance abuse treatment surveys;
- substance abuse treatment as an alternate to incarceration;
- tobacco cessation counseling program;
- community-based environmental tobacco prevention strategies;
- testing retailer compliance with tobacco age requirements;
- analysis of risk factors related to student tobacco use;
- prevention of smokeless tobacco use for youth in rural areas;
- tobacco second-hand smoke surveillance;
- substance use disorder residential treatment; and
- substance use disorder outpatient treatment.

Amount of contracted expenditures in fiscal year 2012: $140,798,499
Number of program contracts: 532 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $2,780,772 | Santa Maria Hostel | Drug treatment services for women and women with children |
| $1,923,702 | Riverside General Hospital | Adult substance abuse treatment services |
| $1,759,741 | Center for Health Care Services | Adult substance abuse treatment services |
| $1,702,375 | MHMR Tarrant County | Adult substance abuse treatment services |
| $1,632,348 | Coastal Bend Alcohol Rehabilitation Center | Adult substance abuse treatment services |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services.

Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

The program awards grants for the following services:

- community coalition partnerships to reduce substance abuse;
- capacity increase for co-occurring psychiatric and substance abuse disorders treatment;
- interpreter services for clients seeking drug treatment;
- early intervention and outreach HIV services for persons with substance use disorders;
- counseling skills training for providers serving clients at risk for communicable diseases;
- behavioral health managed care pilot;
- substance abuse outreach, screening, assessment, and referral services;
- drug and tobacco prevention and intervention for pregnant women;
- drug and tobacco prevention education;
- substance abuse prevention training for youth and adults;
- substance abuse intervention for rural border counties;
- substance abuse prevention incentives;
- school surveys related to substance abuse treatment surveys;
- substance abuse treatment as an alternate to incarceration;
- tobacco cessation counseling program;
- community-based environmental tobacco prevention strategies;
- testing retailer compliance with tobacco age requirements;
- analysis of risk factors related to student tobacco use;
- prevention of smokeless tobacco use for youth in rural areas;
- tobacco second-hand smoke surveillance;
- substance use disorder residential treatment; and
- substance use disorder outpatient treatment.

Using sub-recipient contracts, the program awards grants in the following manner:

- through competitive solicitations, and
- on an emergency or sole source basis when an approved emergency or sole source justification waives competition.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | NorthSTAR Behavioral Health Waiver |
| **Location/Division** | 909 West 45th Street, Austin – Mental Health and Substance Abuse (MHSA) Services Division |
| **Contact Name** | Mike Maples, Assistant Commissioner, MHSA Services Division |
| **Actual Expenditures, FY 2012** | $120,169,145 |
| **Number of Actual FTEs as of June 1, 2013** | 8.3 |
| **Statutory Citation for Program** | Chapter 533, Government Code; Chapters 461, 531-535, and 1001, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

The NorthSTAR Behavioral Health Waiver has as its primary objective to provide MHSA inpatient and outpatient services using a managed care model for adults and children.

NorthSTAR is a behavioral health managed care program in the Dallas service area (Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties) that targets traditional problems of public behavioral health care: consumer access, limitations in provider choice, and lack of accountability. With the introduction of NorthSTAR, the State braided the funding for MHSA services across funding streams and, working cooperatively, created a single system of public behavioral health. Major activities include the following.

**Mental Health Services**
NorthSTAR provides accessible and quality mental health services to the Medicaid and indigent population in the Dallas service area.

**Substance Abuse Services**
NorthSTAR provides accessible and quality substance abuse services to the Medicaid and indigent population in the Dallas service area.

**Texas Resiliency and Recovery Model (TRR)**
In concurrence with DSHS programs across the state, NorthSTAR utilizes the TRR model to deliver mental health services to adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). TRR offers an array of evidence-based services to assist adults and children/adolescents to effectively manage mental illness and achieve recovery.

These include community-based services that assist in stabilizing crises, minimize hospitalizations and re-hospitalizations, restore functioning, assist with adherence to medication regimens, promote integration into the larger community, and assist with linkage to other required community-based services.

**Care Management**
NorthSTAR coordinates services for consumers with multiple disorders.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

The monthly number of persons served provides an indication of NorthSTAR's effectiveness. The fiscal year 2012 target was 60,500. During this time, NorthSTAR served 69,813 persons, achieving 115.4 percent of the target.

The pooled purchasing approach of NorthSTAR transformed separately funded and disparate systems of care with different eligibility requirements into one system of care. This approach provides a comprehensive MHSA benefit package for eligible individuals. The program determines access to benefits based on clinical need, not funding source. Review of data, such as contracted dollars per staff allocated, indicates that the pooled funding approach has resulted in fewer administrative structures for maintaining multiple systems-of-care; therefore, more money is available for client services.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1999** – The legacy TDMHMR implements NorthSTAR, first as mandatory for indigent clients and voluntary for Medicaid Temporary Aid to Needy Families (TANF). DSHS later mandates all Medicaid-eligible persons to enroll, if they had not already chosen a behavioral health organization.

**2000** – TDMHMR implements the mobile crisis system, which changes financial eligibility and pharmacy benefits. Magellan ceases participation in NorthSTAR, and TDMHMR transitions all Magellan enrollees to ValueOptions.

**2001** – TDMHMR establishes the Front Door Evaluation Facility for Acute Care Services (for non-Medicaid adults only) and designates enrollment sites. TDMHMR/NorthSTAR reduces rates for service coordination, substance use disorder services, and psychosocial rehabilitation.

**2004** – DSHS, in conjunction with HHSC, reduces rates for psychosocial rehabilitation and service coordination and eliminates adult counseling and psychological testing as Medicaid benefits. MHSA implements the Resiliency and Disease Management (RDM) model. HHSC eliminates service coordination, but adds case management and new rehabilitation services (skills training and development, medication training and support, rehabilitation counseling, and psychotherapy). New billing requirements eliminate billable travel time for rehabilitation services and reduce the unit of service from 30 minutes (or a portion of) to full 15 minutes. HHSC decreases the pharmacy network size to prepare for the federal 340B Drug Pricing Program.

**2005** – MHSA expands the Front Door Evaluation Facility for Acute Care Services to provide acute care services for Medicaid and child and adolescent populations yet eliminates the services to children and adolescents later that same year. HHSC reinstates Medicaid adult counseling and psychological testing benefits for adults, but eliminates rehabilitative counseling and psychotherapy benefits for adults. DSHS implements the prepayment model for select NorthSTAR providers of outpatient mental health services.

**2006** – DSHS began screening and using telemedicine for the 340B Drug Pricing Program.

**2007-2008** – DSHS eliminates the prepayment contracts with select providers and resumes fee-for-service system of billing.

**2009** – MHSA implements the Outpatient Competency Restoration Program.

**2009-2010** – DSHS establishes a blended case rate for RDM services and makes changes to intensive outpatient and supportive outpatient substance use disorder treatment.

**2011** – DSHS includes adult bed day costs at State Hospitals as a billable service covered by Medicaid premiums for Medicaid enrollees.

**2012** – DSHS includes child day costs at State Hospitals as a billable service covered by Medicaid premiums for Medicaid enrollees.

**2013** – MHSA implements TRR training and competency requirements, which replaces the RDM model.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

Individuals eligible for NorthSTAR are consumers: (1) who meet specific clinical criteria and demonstrate eligibility in the included Medicaid groups, or (2) whose income is below or equal

to 200 percent federal poverty level (FPL) and who lack any other health insurance. MHSA defines the clinical need more specifically for income eligible consumers than for Medicaid-eligible consumers. Medicaid groups included in NorthSTAR are those recipients of TANF and other income eligible programs (such as pregnant women and newborns whose family income is below 185 percent FPL and recipients of Supplemental Security Income). NorthSTAR does not cover Medicaid-eligible persons who reside in nursing homes or community facilities for individuals with intellectual disabilities or related conditions, who are in child protective foster care, or whose Medicaid eligibility is for an emergency only. Other state Medicaid programs provide these individuals with services. Additionally, NorthSTAR serves the large group of indigent consumers identified as the priority populations of DSHS MHSA Services program.

The mental health priority population includes children and adolescents who have a diagnosis of mental illness. The priority population also includes those children and adolescents that exhibit severe emotional or social disabilities and require crisis intervention or prolonged treatment. The adult target populations include individuals with serious mental illness: schizophrenia, major depression, or bipolar disorder.

NorthSTAR covers substance abuse and chemical dependence diagnoses that include the abuse of, the psychological or physical dependence on, or the addiction to, alcohol or a controlled substance, corresponding to the *Diagnostic and Statistical Manual of Mental Health Disorders - Fourth Edition, Text Revision* criteria for substance abuse and substance dependency disorders. NorthSTAR covers persons with substance abuse and chemical dependence diagnoses who meet the following eligibility coverage criteria as clinically indicated.

- Any youth that has a substance abuse or dependency diagnosis is eligible for all covered services.
- Adults with a substance dependency diagnosis are eligible for all covered services.
- Adults with a substance abuse diagnosis are eligible for outpatient treatment programs only.
- Pregnant women, women with dependent children, and parents of children in foster care with substance abuse or dependency diagnoses are eligible for all covered services.
- Persons with human immunodeficiency virus (HIV) with substance abuse or dependency diagnoses are eligible for all covered services.
- Persons with substance abuse or dependency diagnoses who use needles to take drugs are eligible for all covered services.

In fiscal year 2012, NorthSTAR's average monthly enrollment was 466,686 Medicaid clients and 366,068 indigent (non-Medicaid) clients. NorthSTAR is currently serving approximately 27,382 persons per month, and projects serving approximately 72,000 persons in fiscal year 2013. The unduplicated number of people served, as well as the monthly average number of persons served, has steadily increased since the start of the program.

The following chart shows numbers of persons served in the NorthSTAR program since 2000.

| Fiscal Year | 2000 | 2002 | 2004 | 2006 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|
| **Adults** | 24,224 | 29,822 | 37,355 | 37,397 | 40,689 | 46,954 | 48,646 | 54,342 | 51,182 |
| **Children** | 6,628 | 6,427 | 10,309 | 11,159 | 13,101 | 15,253 | 16,614 | 19,351 | 20,487 |
| **Medicaid** | 7,655 | 12,054 | 16,860 | 18,124 | 21,457 | 25,431 | 27,651 | 32,704 | 34,625 |
| **Indigent** | 24,652 | 26,110 | 33,498 | 33,01 | 35,435 | 40,565 | 41,192 | 45,388 | 41,036 |

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The MHSA Services Division, Program Services Section, Medicaid Services Unit and the MHSA Services Division, Contract Services Section, MHSA Contract Unit administer NorthSTAR activities.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $59,690,653 |
| General Revenue | $33,992,691 |
| General Revenue-Dedicated | $0 |
| Other | $26,485,801 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| MHSA Services Division mental health programs | These units oversee provision of mental health services to Medicaid and indigent clients and utilize TRR to assess service package assignments. | Contracts are between the state and the providers. The contractual arrangement has no financial risk. Medicaid programs provide Medicaid clients with MH services. General Revenue allocations pay for indigent client MH services. Once General Revenue funds are |

| Name | Similarities | Differences |
|---|---|---|
| | | depleted, clients may be placed on a waiting list. |
| MHSA Services Division substance abuse programs | These units oversee provision of substance abuse services to indigent clients and utilize the CMBHS system to assess clinical need, document service, and bill for services. | Contracts are between the state and the providers. The contractual arrangement has no financial risk. The federal Substance Abuse Block Grant funding pays for client services. Once block grant funds are depleted, the program may place clients on a waiting list. |

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| HHSC, STAR and STAR Plus Medicaid Managed Care Program | This program provides managed care services to Medicaid clients through a contract with a health maintenance organization (HMO) that manages services and contracts with providers. | STAR and STAR Plus do not serve the non-Medicaid population. The array of behavioral services is more limited. The HMO contracts directly with the state, and the HMO sub-contracts with the behavioral health organization. |
| Children's Health Insurance Program (CHIP) | CHIP provides physical health and behavioral health services to non-Medicaid children and adolescents who meet eligibility criteria. | CHIP is limited to children and adolescent clients who meet eligibility criteria. Client/family pays a monthly amount for participation in CHIP. |
| Medicare | Medicare provides physical health services, behavioral health services, and prescription drugs to individuals enrolled in Medicare. | Medicare is limited to those 65 years or over, or those with a certified disability after 24 months from certification date. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

The NorthSTAR Program administers behavioral health services to Medicaid clients in the Dallas service area provided by behavioral health specialists. The STAR Medicaid Managed Care Program administers behavioral health services in the Dallas service area provided by primary care providers.

NorthSTAR and CHIP coordinate behavioral health services provided to indigent clients in the Dallas service area through a memorandum of understanding. NorthSTAR is the payer of last resort.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Commissioner courts in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties | County commissioner courts are the chief policymaking and administrative branches of county government. | County commissioner courts have agreements to contribute funding to NorthSTAR and to appoint a board of directors to the local behavioral health authority. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Centers for Medicare & Medicaid Services (CMS) | CMS reviews and approves the 1915(b) waiver to require enrollment of Medicaid groups into the NorthSTAR Program. | Under a Medicaid managed care waiver, CMS partially funds Medicaid behavioral health services for NorthSTAR. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The amount of contracted expenditures in fiscal year 2012 was $752,047. The major contract for this program is with North Texas Behavioral Health Authority to provide a comprehensive mental health and substance abuse benefit package. The NorthSTAR Program restructured the traditional fragmented public behavioral healthcare system to a quasi-private insurance model based on the principles of managed behavioral health care. This placed the State in a purchasing, rather than a provider-oriented regulatory role, as DSHS negotiated a contract with private entities to assume full financial risk for the behavioral health care of all populations eligible for federally or state-funded behavioral health care.

Open contracting arrangements with mental health providers replaced direct state block grant funding to traditional public providers, introducing competition into a system that historically lacked both private sector incentives and service-level accountability. Prior to the implementation of NorthSTAR, 25 facility-based providers (including one hospital district) in the Dallas service area served Medicaid and indigent populations. Currently, 45 facility-based providers and 212 individual providers in the Dallas service area serve the Medicaid and indigent populations.

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

The program does not award any grants.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

Performance data and additional information is available at:
http://www.dshs.state.tx.us/mhsa/northstar/northstar.shtm.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**

- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Hospital Services |
| **Location/Division** | 909 West 45th Street, Austin – Mental Health and Substance Abuse (MHSA) Services Division |
| **Contact Name** | Mike Maples, Assistant Commissioner, MHSA Services Division |
| **Actual Expenditures, FY 2012** | $475,463,625 |
| **Number of Actual FTEs as of June 1, 2013** | 7,974.2 |
| **Statutory Citation for Program** | Section 11.004, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Hospital Services has the following primary objectives.

- Provide for more than one level of care of tuberculosis (TB), Hansen's disease, and other infectious diseases.
- Provide outpatient services for the screening, evaluation, and intervention for chronic disorders, including TB, well-women exams, prescription assistance program, and referral services/linkages to medical service.
- Provide specialized inpatient psychiatric assessment, treatment, and medical services.
- Provide psychiatric residential treatment for adolescents at Waco Center for Youth.

Major activities include the following.

**Infectious Diseases**

Texas Center for Infectious Diseases (TCID) is the designated hospital for court-ordered (quarantined) TB treatment when a patient's non-adherence with TB medication regimens has proven to be a threat to public health or safety. TCID treats 4-6 percent of the patients with TB in Texas who are the most complicated cases and who are unable or unwilling to seek care in the community, when hospitalization is indicated for six months to two years duration to cure.

**Rio Grande State Center (RGSC) Outpatient Services**

RGSC provides outpatient clinic services that include screening, evaluation, and intervention for chronic disorders, including TB; primary care physician services; health education on disease prevention, exercise, nutrition, and lifestyle changes; well women exams; sexually transmitted disease screening; radiography; ultrasonography; pulmonary function tests; Holter monitors; diabetes education; and psychological services.

**Inpatient Psychiatric Services**
DSHS provides psychiatric inpatient hospital services for adults, geriatrics, adolescents, and children. Services include diagnostics, treatment, liaison with appropriate courts and law enforcement, and discharge planning. DSHS also provides psychiatric residential treatment for youth (ages 10-17). Services include structured therapeutic programming and discharge planning.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

Hospitals maintain accreditation by The Joint Commission (TJC), which accredits nearly 15,000 healthcare organizations and programs in the United States. TJC standards address the hospital's level of performance in key functional areas: patient rights, patient treatment, patient safety, medication management, infection control, performance improvement, leadership, and information management.

Hospitals also maintain certification from the Centers for Medicare & Medicaid Services (CMS) through their successful accreditation by TJC for participation in the Medicare hospital and long-term acute hospital programs.

Hospitals maintain an extensive array of measures by which they continuously evaluate performance and identify areas of improvement. Hospital Services collates the measures from all hospitals in the Statewide Performance Indicators. Individual hospitals report on additional measures through the governing body process.

**Infectious Diseases**
TCID is one of the six centers of excellence granted by the Centers for Disease Control and Prevention (CDC), the Heartland National Tuberculosis Center, and the Midwest Regional Training and Medical Consultation Center.

**Inpatient Psychiatric Services**
Statewide performance indicators include the Legislative Budget Board measures and ORYX, TJC's performance measurement and improvement initiative. Hospitals submit ORYX measures through the National Association of State Mental Health Program Directors National Research Institute (NRI). The NRI Performance Measurement System serves more than 200 State Hospitals reporting ORYX measures and facilitates extensive comparison and evaluation with State Hospitals throughout the nation. The NRI measures include areas such as restraint, seclusion, injuries, elopements, and patient satisfaction. The statewide performance indicators also include measures selected by the State Hospital governing body for process improvement.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**2001-2013** – During this time, the forensic population's use of state mental hospital resources has increased from 16 percent in 2001 to 37 percent in 2010. The forensic population refers to those patients with mandatory hospitalizations due to "Not Guilty by Reason of Insanity" commitments and "Competency Restoration" commitments. This increase causes a corresponding reduction of beds for patients with civil commitments.

**2004** – Effective September 1, 2004, DSHS consolidated management of state mental health hospitals, TCID, and the South Texas Health Care System under the DSHS State Hospitals Section.

**2008** – DSHS completes the last of 25 administrative, clinical, and support service consolidations and program integrations between TCID, San Antonio State Hospital (SASH), and San Antonio State Supported Living Center.

**2010** – DSHS completes the remodel and new construction projects at TCID and RGSC Outpatient Clinic. Patients relocate to remodeled new facilities in September, and outpatient services relocate in November.

**2011** – DSHS converts 120 beds in the State Hospitals to residential beds, saving $3 million (40 beds at each Big Spring, Rusk, and San Antonio State Hospitals). TJC accredits these new programs under the commission's behavioral health standards.

**2012** – In response to the Disability Rights Texas lawsuit, DSHS adds 40 maximum-security beds to North Texas State Hospital (NTSH) and converts 60 non-maximum-security forensic beds to maximum-security at Rusk State Hospital (RSH). DSHS converts 60 more civil commitment beds at NTSH (Wichita Falls), RSH, and SASH to non-maximum-security forensic beds. DSHS purchases 60 new beds for civil commitments from private psychiatric hospitals through local mental health authorities (LMHAs). The agency also develops a 30-bed longer-term psychiatric treatment unit at the University of Texas Health Science Center at Tyler (UTHSC-Tyler) that operates as a unit of RSH.

**2012** – DSHS implements new processes for monitoring abuse and neglect in the State Hospital system. DSHS provides counseling to employees with two or more allegations of abuse and neglect within a year. Managers identify and mandate counseling for employees with two or more allegations of sexual abuse from the time of employment. The Assistant Commissioner of the MHSA Services Division receives a daily report of all allegations of Class I physical abuse and sexual abuse. DSHS reports all allegations of abuse by a physician to the Texas Medical Board. Other licensing boards require that DSHS report confirmations of abuse.

**2013** – DSHS implements a new process that requires the Director of the State Hospital Section to approve all psychiatrists employed in the State Hospitals after a careful review that includes a criminal background check.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

**Infectious Diseases**
The Legislature authorizes TCID to treat persons with complicated TB who reside or intend to reside in Texas. Persons who are unwilling or unable to follow medical advice for TB receive hospitalization for six months to two years. TCID is the designated hospital for court-ordered (quarantined) TB treatment where a patient's non-adherence with TB medication regimens has proven to be a threat to public health or safety. TCID treats all patients with Hansen's disease in the outpatient clinic, one of four clinics statewide contracting with DSHS for these patient services.

**RGSC Outpatient Services**
RGSC Outpatient Services provides services to residents of Cameron, Hidalgo, Starr, and Willacy counties. The clinic accepts Medicare, Medicaid, and third party payers. For those with no health insurance who do not qualify for any other program assistance, the clinic offers a sliding scale payment option based on income, family size, assets, and other guidelines. The top three diagnoses in fiscal year 2012 were hypertension, hyperlipidemia, and diabetes.

**Inpatient Psychiatric Services**
DSHS provides Inpatient Psychiatric Services to Texas residents who are experiencing severe mental illness and require treatment in an inpatient facility, as well as offenders in local judicial systems and law enforcement agencies. To be eligible for services, a person must have a mental illness and, as a result of the mental illness, present a substantial risk of serious harm to self or others, or evidence a substantial risk of mental or physical deterioration.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The MHSA Services Division, State Hospitals Section administers Hospital Services. The State Hospitals Section administratively manages the hospitals according to the State Hospitals Section bylaws for governing bodies. The governing body establishes hospital policy and approves a hospital management plan for each hospital. This plan establishes goals and performance indicators for the State Hospitals. The governing body is responsible for the following:

- quality of care that each hospital provides,
- planning and managing the organization,
- implementing performance improvement,
- credentialing of the medical staff,
- providing financial management, and
- ensuring that managers assess the competence of all staff members and confirm that staff demonstrate and improve competency.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $20,269,328 |
| General Revenue | $376,392,801 |
| General Revenue-Dedicated | $935,589 |
| Other | $77,865,907 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Private psychiatric hospitals or psychiatric unit in general hospitals | Private hospitals provide psychiatric inpatient hospital services. Services include diagnostics, treatment, and discharge planning. | Some hospitals are not able to provide services to patients who are experiencing the most severe of mental illnesses and/or are manifestly dangerous or grossly aggressive and/or require forensic services. The method of reimbursement for services may also be a factor. |
| Private residential treatment centers (RTC) | Private RTCs provide psychiatric residential treatment services. Services include structured therapeutic programming and discharge planning. | Some private RTCs are not able to provide services to patients who require specialized therapeutic programming. Method of reimbursement for services |

| Name | Similarities | Differences |
|---|---|---|
| | | may also be a factor in determining service type. |
| UTHSC-Tyler | Both UTHSC-Tyler and TCID have isolation rooms in a contiguous patient care unit, and laboratory, radiology, pharmacy, chaplaincy, and social work services. The medical director serves both facilities. Both participate in and support functions of the Heartland National Tuberculosis Center. TJC accredits both hospitals. | UTHSC-Tyler is a Medicare-certified acute hospital. TCID is a Medicare-certified long-term acute specialty hospital.<br><br>UTHSC-Tyler has limited programs for long lengths of stay. UTHSC-Tyler has acute care services, such as surgery and intensive care, available on site, which TCID does not provide. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

House Bill 1748, 76th Legislature, Regular Session, 1999, authorizes and describes the parameters of a working relationship among TDH (now DSHS), TCID and TB Elimination Programs; UTHSC-Tyler; and University of Texas Health Science Center-San Antonio. These include the provision of direct patient care services, education, information and referral, case management, and research in support of the public health functions required for statewide TB control. Even prior to the reorganization of the health and human services agencies, SASH and TCID were working together to share functions. Since the reorganization in 2004, 25 administrative, clinical, and support functions serve all or parts of the 15 permanent state agency, academic, and local programs. DSHS secured memorandums of agreement, interagency contracts, intra-agency service level agreements, and grant awards for each level of interaction among the participants in service provision affecting TCID.

Hospital Services consider State Hospitals to be the "provider of last resort." Each State Hospital has a Utilization Management Agreement with the local LMHA. DSHS also has a contract with each LMHA in the state. Both the agreement and the contract require the LMHA to screen an individual seeking mental health services to determine if the individual requires inpatient psychiatric services. If the screening and assessment indicates inpatient psychiatric services, the LMHA determines the least restrictive treatment setting available. In other cases, a hospital physician screens an individual presenting for admission to a State Hospital when the LMHA has not screened and referred the individual. The hospital physician determines if the person has an emergency psychiatric condition that is appropriate for admission to the State

Hospital or if the person requires a referral to the LMHA to coordinate alternate services. The physician will also determine if a life-threatening medical condition exists, which may require care in a medical hospital.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Justice of the peace courts and county courts | Justice of the peace courts and county courts issue civil mental health commitments to State Hospitals. | DSHS serves patients committed to State Hospitals. |
| District courts | District courts issue forensic commitments to State Hospitals. | DSHS serves patients committed to State Hospitals. |
| Law enforcement | City police and county law enforcement transport patients to hospitals for admission and/or to court for scheduled legal proceedings. | DSHS receives patients for admission. |
| Local health departments (LHDs), TB program managers | LHDs provide healthcare services to their respective constituents. | LHDs are contractors with DSHS. |
| Bexar County Hospital District (University Health System) | The University Health System is a local public general hospital and clinic system supporting TCID patient care. | This hospital district is a contractor with DSHS. |
| LMHAs | LMHAs screen persons seeking mental health services to determine if the person requires inpatient psychiatric services. If the screening and assessment indicates the person requires inpatient psychiatric services, the LMHA determines the least restrictive treatment setting available. | DSHS contracts with LMHAs to provide mental health services in a designated geographic area. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| CMS | Hospitals must comply with CMS Conditions of Participation to maintain Medicare certification and receive Medicare reimbursement. | CMS is a contractor and source of funding. |
| CDC | CDC provides information to enhance health decisions and promotes health through partnerships with state health departments and other organizations. | CDC is a contractor and a source of funding for the Heartland National Tuberculosis Center. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts in this program for the following:

- healthcare professional service,
- temporary staffing,
- pharmacy service,
- lab and radiology services,
- building maintenance and supplies,
- food services and groceries,
- data collection and processing, and
- psychiatric residency program.

Amount of contracted expenditures in fiscal year 2012: $66,760,216
Number of program contracts: 637 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $1,534,968 | Labatt Foodservices LP | Food services for clients |
| $1,373,698 | United Regional Health Care System, Inc. | Medical services for clients |

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $1,273,952 | Seton Family of Hospitals | Medical services for clients |
| $1,107,390 | East Texas Medical Center | Medical services for clients |
| $906,228 | Truman Arnold Company | Bulk fuel |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

The program does not award any grants.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory changes to assist the program in performing its functions.

**Criminal Background Checks** – Allow DSHS to perform criminal background checks on physicians contracting with hospitals. Currently, DSHS can perform checks on potential employees; contracts require *locum tenens* companies to complete criminal background checks on physicians they refer.

**Competency Restoration** – Mandate that prisoners in the Texas Department of Criminal Justice who commit crimes while in prison cannot be sent to a State Hospital for competency restoration until they have completed serving their sentence.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

**Family and Community Health Services (FCHS) Division**
Evelyn Delgado, Assistant Commissioner

**FTEs: 399.6**

The FCHS Division provides oversight, monitoring, and strategic direction for programs that increase access to health care through community collaboration, with a focus on prevention. The division provides healthcare safety net services and population-based services across the state. Services include women and children's health services, family planning, primary healthcare services, specialized health services, nutrition and obesity prevention services, and community capacity building. Detailed information about each of these services is included in a separate Section VII description.

DSHS organizes the division into the three sections and one office that report to the Assistant Commissioner.

- Community Health Services Section coordinates development of policies and procedures for programs, and reviews and approves quality assurance plans, strategies for monitoring service delivery, and statewide objectives to improve access to community-based care.
- Specialized Health Services Section directs multiple programs that provide for preventive and acute health care; health screening; and case management services to targeted populations, including children with certain conditions, high-risk pregnant women, and adults with kidney disease or hemophilia.
- Nutrition Services Section provides overall direction, policy development, and policy enforcement for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The section also serves as the state liaison to the U.S. Department of Agriculture (USDA).
- Office of Title V and Family Health is responsible for the Title V Maternal and Child Health Block Grant and the Promotor(a) or Community Health Worker Training and Certification Program.

Note: The Nutrition, Physical Activity and Obesity Prevention Program, included in the Section VII description for Nutrition and Obesity Prevention Services, is funded through an FCHS strategy, but is administered by the Disease Control and Prevention Services Division.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Women and Children's Health Services |
| **Location/Division** | 1701 North Congress - Family and Community Health Services (FCHS) Division |
| **Contact Name** | Evelyn Delgado, Assistant Commissioner, FCHS Division |
| **Actual Expenditures, FY 2012** | $78,310,359 |
| **Number of Actual FTEs as of June 1, 2013** | 464.4 |
| **Statutory Citation for Program** | Chapter 32, 33, 36, 37, 43, 47, and 48, Texas Health and Safety Code; Chapter 264, Family Code; 42 U.S.C. Chapter 7, Subchapter V |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

The Women and Children's Health Services (WCHS) Program has the primary objective to develop and support primary healthcare and nutrition services to children, women, families, and other qualified individuals though community-based providers. Major activities include the following.

**Breast and Cervical Cancer Services (BCCS) Program**

The BCCS Program provides screening and diagnostic services for breast and cervical cancer to women at or below 200 percent federal poverty level (FPL) that do not have access to these services through other programs or resources. Services include clinical breast and pelvic exams, mammograms, biopsies, pap smears, colposcopies, case management, and client education. The major functions of this program follow.

- Screen and diagnose women, with priority given to low-income women.
- Provide appropriate referrals for medical treatment.
- Develop and disseminate public information and education programs.
- Improve the education, training, and skills of health professionals.
- Monitor the quality and interpretation of screening procedures.
- Evaluate the above activities.

**Title V Maternal and Child Health Fee-for-Service (MCH FFS) Program**

The MCH FFS Program provides prenatal medical and dental care and case management services for pregnant women, and preventive and primary health care, dental care, and case management services for children and adolescents. Clients must have an income at or below

185 percent FPL and must not have access to these services through other programs or resources. The MCH FFS Program provides limited coverage for direct care while clients complete the eligibility process for Medicaid and Children's Health Insurance Program (CHIP).

**School Health Services**

School Health Services support the development of coordinated school health programs statewide with emphasis on school health promotion. The program provides funding to establish, expand, or operate school-based health centers to deliver primary and preventive services to children and adolescents in the school setting with additional focus on chronic disease management.

**Population-Based Screening Services**

- The Newborn Screening (NBS) Program follows up on all abnormal screens for 29 genetic disorders detected by blood tests to ensure notification of newborn primary care providers or pediatricians. Staff continues follow-up until a medical specialist makes a diagnosis or clears the newborn of an abnormal result.
- The Newborn Hearing Screening (NBHS) Program:
    - certifies birth facilities required to offer screening of infants to detect a potential hearing loss;
    - ensures that infants who fail the screening are referred for a follow-up screen as an outpatient, and that babies failing the outpatient screen are referred to Early Childhood Intervention; and
    - contracts with a vendor to maintain the Texas Early Hearing Detection Intervention system, into which hospitals and birthing centers enter hearing screen results.
- The Vision and Hearing Program identifies, at as early an age as possible, children who have special senses and communication disorders and who need remedial vision and hearing services.
- The Spinal Screening Program trains and certifies individuals to identify children with abnormal spinal curvature and refers them for further evaluation.

**Texas Health Steps (THSteps)**

Under authority of Title XIX of the Social Security Act and through an interagency contract with HHSC, THSteps provides for administrative functions related to periodic medical and dental checkups for Medicaid children birth through age 20. The program provides outreach to ensure client awareness of existing benefits and services; and works to assist in recruiting, retaining, training, educating, and providing technical assistance to existing and potential THSteps providers as well as others who work with recipients. The program participates in activities associated with compliance for the *Frew, et al. vs. Janek, et al.* consent decree, and provides children with severe or complex health problems case management services to assure optimum access to medical and dental services. Additionally, the program recruits and trains case management providers to enhance eligible client access to needed services and resources.

**Oral Health Program (OHP)**
OHP provides preventive oral health services to eligible preschool and school age children, and conducts oral health surveillance activities in order to obtain baseline data on the oral health of Texans.

**Administration of Medicaid Services**

- The Case Management for Children and Pregnant Women Program provides health-related case management services to eligible children and pregnant women. Case Management for Children and Pregnant Women services include assessing the needs of eligible clients, formulating a service plan, making referrals, problem-solving, advocacy, and follow up regarding client and family needs.
- The Personal Care Services Program is a Medicaid benefit that provides assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to clients, age birth through age 20. ADLs and IADLs may include toileting, dressing, transfers, and other approved tasks. Consumers must have physical, cognitive, or behavioral functional limitations related to a disability, physical or mental illness, or chronic condition. DSHS regional staff determines eligibility and authorizes services that Medicaid-enrolled providers deliver.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

The WCHS Program uses key statistics and performance measures to evaluate effectiveness and efficiency of the program activities.

**Breast and Cervical Cancer Services Program**
The Centers for Disease Control and Prevention (CDC) requires monitoring and reporting on program effectiveness and efficiency. The BCCS Program maintains a clinical database with client information that the program must submit to the CDC. The following table shows some of the key CDC-required performance indicators.

| CDC Program Performance Indicator | CDC Standard | Texas BCCS Results (July 2011 - June 2012) |
|---|---|---|
| Percentage of women screened for cervical cancer that have never or rarely been screened | ≥ 20 percent | 20% |
| Percentage of women receiving mammograms that are ≥ 50 years of age | ≥ 75 percent | 100% |
| Percentage of women diagnosed with cervical cancer who began treatment more than 60 days after diagnosis | ≤ 20 percent | 4.4% |

| CDC Program Performance Indicator | CDC Standard | Texas BCCS Results (July 2011 - June 2012) |
|---|---|---|
| Percentage of women diagnosed with breast cancer who began treatment more than 60 days after diagnosis | ≤ 20 percent | 3.1% |

CDC also requires reporting on financial expenditure data with the expectation that the program spends at least 95 percent of funds by the end of the budget period. The BCCS Program consistently expends approximately 96 percent of awarded funds.

**Newborn Hearing Screening Program**

The NBHS Program has screened approximately four million infants during the 11 years it has been in place. The program performance continues to align with the nationally established benchmark for screening. The NBHS Program screens more than 98 percent of babies, with less than 4 percent of the babies failing the birth screen. In fiscal year 2012, the program completed hearing screens on 369,424 newborns.

**Texas Health Steps**

CMS issues an annual report (CMS 416) that measures the state's performance in THSteps in comparison with federal goals of participation rates. The Omnibus Budget Reconciliation Act of 1989 required state-specific goals for children's participation in Early and Periodic Screening, Diagnosis and Treatment. To fulfill this requirement, in 1990, the Health Care Financing Administration (renamed CMS) set a participation goal of 80 percent by 1995 for every state as measured by the CMS 416 report. Per the 2012 CMS 416 report, THSteps reported a participation rate in Texas of 62 percent.

**Oral Health Program**

OHP obtains statistically valid baseline data through surveillance activities and other nationally recognized surveillance tools. OHP uses this data to identify opportunities for preventive interventions and for comparison to additional surveillance activities undertaken, based on the OHP Surveillance Plan. Data show that 33 percent of preschool and elementary children have untreated dental disease and approximately 7 percent of preschool children have urgent dental needs. In 2012, OHP provided 10,489 children with preventive dental health services.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1990** – Public Health Service Act, Title XV, 42 U.S.C. Section 300k, *et seq*., authorizes CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and Public Law 101-354 "Breast and Cervical Cancer Mortality Prevention Act of 1990" establishes the early detection program.

**1991** – Texas Department of Health (now DSHS) is one of four states first awarded funds, under a cooperative agreement from CDC, to provide breast and cervical cancer screening services to low-income women. In subsequent years, Texas is the first state to conduct diagnostic and case management services, in addition to screening services. Subsequently, Texas receives federal funding to expand and continue diagnostic and case management services.

**1998** – Public Law 105-340, the "Women's Health Research and Prevention Amendments of 1998," amends NBCCEDP services to include case management in the BCCS Program.

**1998** – DSHS implements Targeted Case Management for Pregnant Women and Infants to comply with the *Frew, et al. v Suehs, et al.* consent decree.

**2000** – Congress passes the Breast and Cervical Cancer Prevention and Treatment Act (Public Law 106-354), which gave states the option to offer women receiving services from NBCCEDP access to cancer treatment through Medicaid. Texas Medicaid provides this option to eligible women diagnosed with a breast or cervical cancer by any Texas provider. Medicaid for Breast and Cervical Cancer (MBCC) is the name of this program.

**2001** – CMS offers states three options for the manner in which eligible woman enter the Medicaid treatment program. Texas implements Option 1 in 2002. Option 1 is the most restrictive option and requires that, in order to qualify for MBCC, a healthcare provider must diagnose a woman within the BCCS Program using federal Title XV funds.

**2003** – The Legislature transfers state funding for THSteps client services to HHSC.

**2005** - The Legislature transfers state funding for administrative costs to HHSC. DSHS continues to conduct day-to-day services for THSteps medical, dental, and case management. The *Frew, et al. vs. Suehs, et al.* lawsuit and subsequent consent decree and corrective action orders continues to guide program activities.

**2005** – As a result of H.B. 790, DSHS expands the panel of disorders screened by the NBS Program from 7 to 27 disorders detectable by blood tests.

**2007** – Senate Bill 10 directs DSHS to define the Texas BCCS Program as CMS Option 3. Option 3 provides that, regardless of the funding source, a woman screened and diagnosed under the BCCS Program who meets additional MBCC eligibility criteria will be eligible for MBCC.

**2007** – HHSC begins implementation of a new expanded perinatal benefit of CHIP. DSHS works closely with HHSC to ensure that Title V-funded prenatal care does not duplicate the new benefit package. Since income eligibility requirements for Title V prenatal services are more restrictive than those of the newly expanded CHIP Perinatal, ineligible women previously served by Title V could be served under the new program's eligibility guidelines. Policy requires that Title V contractors assist clients in the application process for CHIP Perinatal and allows the

providers to seek reimbursement for up to two prenatal visits if occurring during the program application time.

**2009** – Through exceptional item funding approved by the Legislature, the NBS Program begins screening for cystic fibrosis, the final disorder that the American College of Medical Genetics recommends for newborn screening, bringing the total to 28 disorders.

**2010** – DSHS works to implement all components of the 2007 *Frew, et al. vs. Suehs, et al.* Corrective Action Order. HHSC contracts with a vendor to conduct an independent study in fiscal year 2009 to determine effective strategies for outreach to potential clients, informing healthcare professionals about Case Management for Children and Pregnant Women, and recruiting and retaining providers for Case Management for Children and Pregnant Women.

**2012** – The NBS Program begins screening for severe combined immunodeficiency, bringing the total number of screened genetic disorders detected by blood tests to 29.

**2013** – House Bill 740 adds screening for critical congenital heart disease, a disorder not detected by a blood test. The NBS Program plans to implement this point-of-service testing at birthing facilities in 2014.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

**Breast and Cervical Cancer Services Program**

Affected populations are uninsured, low-income women at or below 200 percent FPL who are most at risk for developing breast or cervical cancers and who are not eligible for other resources or programs. Priority populations are women ages 50-64 for breast cancer screening and women over age 21 never or rarely screened for cervical cancer. In fiscal year 2012, 44 BCCS contractors provided services to 42,901 clients (66 percent Hispanic, 33 percent non-Hispanic, and 1 percent unknown; 41 percent 0-39 years, 24 percent 40-49 years, 33 percent 50-64 years, and 2 percent over 65 years).

**Title V Maternal and Child Health Fee-for-Service Program**

The population served is low-income women and children with incomes at or below 185 percent FPL, that are Texas residents, and that are not eligible for other programs or services.

**School Health Services**

The School Health Program provides technical assistance to all public and private schools and school health advisory councils in the state on school health programs, practices, and policies. In addition, the School Nurse Consultant provides training and technical assistance to school administrators and school nurses related to school nursing practice. In the 2010-11 biennium,

DSHS funded 10 school-based health centers (SBHCs). Over 90,000 students across 448 campuses had access to DSHS-funded SBHCs. The centers reported 39,855 visits and enrolled 12,849 students and 2,468 non-students, including siblings and community members in programs.

**Population-Based Screening Services**

This program provides screening for 29 genetic disorders detected by blood tests to all children born in Texas. Legislation in 2013 mandates a screen for an additional disorder not detectable by a blood test. All children born in Texas birthing facilities (as defined in statute) receive newborn hearing screenings. In fiscal year 2012, 2.7 million children in school and day care received vision screenings; 2.6 million received hearing screenings. Additionally, 751,352 adolescents in schools received spinal screenings. Of these, 368,640 were females and 382,712 were males.

**Texas Health Steps**

Medicaid recipients, 0-21 years old, are eligible for the THSteps Program. Preschool and school age children in schools where 85 percent or more of the population is eligible for the free and/or reduced lunch program receive oral health services. In fiscal year 2012, 3.1 million children received medical check-ups and 1.7 million children received dental check-ups through the THSteps Program. The table below provides the number of children receiving services by age group.

| Age | Medical Check-Ups | Dental Check-Ups |
|---|---|---|
| Less than 1 year | 697,000 | 800 |
| 1-2 years | 906,000 | 39,000 |
| 3-5 years | 505,000 | 403,000 |
| 6-9 years | 396,000 | 504,000 |
| 10-14 years | 387,000 | 470,000 |
| 15-18 years | 175,000 | 232,000 |
| 19-20 years | 13,000 | 38,000 |

**Administration of Medicaid Services**

The Case Management for Children and Pregnant Women Program has the following eligibility criteria: Medicaid recipients, 0-21 years old, with a health condition or health risk who need help accessing services and desire program services; or Medicaid recipients experiencing a high-risk pregnancy, who need help accessing services and desire case management services.

The Personal Care Services Program has the following eligibility criteria: Medicaid recipients, 0-21 years with physical, cognitive, or behavioral limitations related to a disability or a chronic health condition. The disability or condition must inhibit the client's ability to accomplish ADLs or IADL.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

**Breast and Cervical Cancer Services Program**

The FCHS Division, Community Health Services Section, Primary and Preventive Care Unit administers the BCCS Program. The BCCS policy/procedure manual is available for review at http://www.bccstexas.com.

Program and contract support staff are located at DSHS central office in Austin and at the health service regional offices statewide. Central office staff is responsible for administering the BCCS cooperative agreement with CDC; collecting data required by CDC; developing program rules, policies, and procedures; and providing contract development, management, support, and oversight. Regional office staff provides technical assistance and training to contractors.

**Title V Maternal and Child Health Fee-for-Service Program**

The FCHS Division, Office of Title V and Family Health (OTVFH) provides policy oversight for the MCH FFS Program. The MCH FFS policy/procedure manual is available for review at http://www.dshs.state.tx.us/mch/.

Program and contract support staff are located in OTVFH and Community Health Services Section at DSHS central office in Austin and at the health service regional offices statewide. Central office staff is responsible for administering MCH FFS; developing program rules, policies, and procedures; and providing contract development, management, support, and oversight. Regional office staff provides technical assistance and training to contractors.

**Population-Based Screening Services**

The FCHS Division, Specialized Health Services Section, Newborn Screening Unit administers the NBS Program and the NBHS Program. NBS nurses and public health and prevention specialists coordinate with providers, families, and specialists for timely clinical care, diagnosis confirmation, and treatment. The NBHS Program provides software and technical assistance to birth facilities and hospitals, certifies birthing facilities, monitors hospital and birthing centers certification standards, oversees the Texas Early Hearing Detection and Intervention information system, and ensures follow-up services and intervention for newborns identified with hearing loss.

The FCHS Division, Specialized Health Services Section, Health Screening and Case Management Unit administers the Vision and Hearing and Spinal Screening Programs. Both programs provide trainings to certify individuals as vision, hearing, and spinal screeners and collect statistical data from required reporting facilities.

**Title V Maternal and Child Health Population Based Services**
The FCHS Division, OTVFH oversees the planning and coordination of statewide activities addressing maternal and child health national and state performance measures. Staff members collaborate with other program areas within the agency and oversee the work of contractors and staff in DSHS health service regions. These activities include child fatality review and injury prevention, improved birth outcomes, childhood obesity prevention, healthy adolescent development, and prevention of teen pregnancy.

**Texas Health Steps**
The FCHS Division, Specialized Health Services Section, Health Screening and Case Management Unit administers the THSteps Program collaboratively with HHSC. THSteps works with the HHSC Office of the Medical Director, Medicaid CHIP, and multiple other HHSC program areas to establish both medical and dental policy, as well as work with the current claims administrator to address provider concerns and encourage both new and existing provider participation. THSteps central office staff works in collaboration with regional THSteps staff to ensure day-to-day THSteps provider-based activities occur. DSHS THSteps staff participates in activities that include policy development; collaboration with internal public health partners; stakeholder engagement, outreach, and informing; community collaborations; and improving access to care by working with providers to encourage their new or existing participation in program services.

**Oral Health Program**
The FCHS Division, Specialized Health Services Section, Health Screening and Case Management Unit administers OHP. The OHP manager/state dental director provides programmatic and professional guidance and direction to other central office and regional program staff. OHP responsibilities include updating dental-related Medicaid/CHIP policies and materials, implementing the Medicaid Dental Frew Strategic Initiatives, and reporting to the court on *Frew, et al. vs. Janek, et al.* lawsuit dental activities. The Frew lawsuit activity report includes the corrective action order on dental assessment. OHP coordinates these activities with counterparts at HHSC and their various Medicaid contractors.

**Administration of Medicaid Services**
The FCHS Division, Specialized Health Services Section, Health Screening and Case Management Unit administers the Case Management for Children and Pregnant Women Program and the Personal Care Services Program. Case Management for Children and Pregnant Women Program staff in central office works closely with DSHS regional specialized health/social services staff to ensure consistent implementation of case management and Personal Care Services eligibility and service authorizations.

**School Health Services**
The Disease Prevention and Control Services Division, Health Promotion and Chronic Disease Prevention Section administers the School Health Services Program. Program staff is located at DSHS central office in Austin. The staff of the School Health Program serves as a central resource and clearinghouse for regional, statewide, and national materials and information for

communities to meet the health services, education and program needs of children in Texas schools.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $45,616,772 |
| General Revenue | $21,562,700 |
| General Revenue-Dedicated | $0 |
| Other | $11,130,887 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Breast and Cervical Cancer Services Program - Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| Title V MCH FFS | MCH FFS provides dysplasia services that screen for cervical cancer. | MCH FFS does not provide advanced screening or diagnostic services. The program serves clients up to 185 percent FPL, whereas BCCS serves up to 200 percent FPL. |
| DSHS Family Planning | DSHS Family Planning may provide clinical breast exams and pap smears to preliminarily screen for breast and cervical cancer. | DSHS Family Planning does not provide advanced screening or diagnostic services. DSHS Family Planning serves clients up to 250 percent FPL, whereas BCCS serves up to 200 percent FPL. |
| Primary Health Care | Primary Health Care may provide clinical breast exams and pap smears to preliminarily screen for breast and cervical cancer. | Traditional Primary Health Care does not provide advanced screening or diagnostic services conducted outside of the clinic setting. In fiscal year 2014, Primary Health Care will serve clients up to 200 percent FPL. |

**Breast and Cervical Cancer Services Program - External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Medicaid | Medicaid provides breast and cervical cancer screening and | Medicaid provides coverage for treatment of breast and cervical cancer |

| Name | Similarities | Differences |
|---|---|---|
| | diagnostic services to women. | to eligible women. Medicaid serves Medicaid-eligible women, whereas BCCS serves non-Medicaid eligible women up to 200 percent FPL. |

**Title V Maternal and Child Health Fee-for-Service - Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| THSteps | MCH FFS and THSteps covered child health benefits are similar. | THSteps serves Medicaid-eligible children, whereas MCH FFS serves children not eligible for Medicaid up to 185 percent FPL. |
| Primary Health Care | MCH FFS and Primary Health Care covered child health and prenatal benefits are similar. | MCH FFS serves up to 185 percent FPL. In fiscal year 2014, Primary Health Care will serve clients up to 200 percent FPL. |
| OHP | OHP and MCH FFS both provide dental benefits to low-income children. | OHP covered benefits for low-income children are limited to sealants. |

**Title V Maternal and Child Health Fee-for-Service - External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Medicaid | Medicaid provides prenatal, dysplasia, and child health services. | Medicaid serves Medicaid-eligible women and children, whereas MCH FFS serves non-Medicaid eligible women and children up to 185 percent FPL. |
| CHIP | CHIP provides child health services. | CHIP serves CHIP-eligible children, whereas MCH FFS serves non-CHIP eligible children up to 185 percent FPL. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

Medicaid and CHIP are available statewide; however, the BCCS Program does not currently serve anyone under 18 years of age. Traditional Medicaid has significantly different eligibility requirements than BCCS. The eligibility determination process for each of the programs helps contractors and providers direct clients to the available and most appropriate services in their respective communities. DSHS promotes collaboration among contractors of all funding sources to minimize duplication of services. DSHS requires contractors to identify other potential resources or programs that may serve clients to ensure that clients only utilize DSHS programs as safety net programs.

OHP has conducted a statewide survey of community and academic programs that offer preventive dental services in Texas to identify potential partners and/or collaborative opportunities. OHP has used survey results to identify the various entities' operational limitations and avoid duplication and/or conflict with these programs and their activities. OHP has established memoranda of understanding and interagency agreements with community and academic partners in order to ensure written understanding of the scope of collaboration and activities undertaken between the parties.

The Case Management for Children and Pregnant Women Program coordinates services with all Health and Human Services System agencies including the Department of Family and Protective Services, the Department of Aging and Disability Services, and the Department of Assistive and Rehabilitative Services. The *Analysis of Case Management Report* conducted by Navigant Consulting through a contract with HHSC is available online at:
http://www.hhsc.state.tx.us/about_hhsc/reports/CaseManagement_Analysis.pdf

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Local health departments, public hospitals, and hospital districts | Local agencies that provide healthcare services to their respective constituents. | These local agencies contract with DSHS to provide BCCS Program and MCH FFS services. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| CDC | CDC is responsible for protecting the health and safety of all Americans and for providing essential human services, especially for those people who are least able to help themselves. | A cooperative agreement with CDC provides guidance and funding to carry out breast and cervical cancer early detection activities in Texas. |
| Health Resources and Services Administration (HRSA) | HRSA is responsible for improving access to healthcare services for people who are uninsured, isolated, or medically vulnerable. | The Title V Block Grant administered by HRSA provides guidance and funding to carry out maternal and child health services. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts in this program for the following:

- prenatal care;
- preventive and primary child care;
- dental care for children and adolescents;
- comprehensive local system for health and well-being of youth;
- community health worker study;
- community-level, evidence-based interventions to decrease infant mortality and improve birth outcomes;
- curriculum for prenatal health care;
- policy development to support worksite breastfeeding;
- sexual violence prevention activities;
- assessments and evaluations;
- breast and cervical cancer screening, diagnosis, and referral;
- case management;
- client and healthcare professional education;
- internship program;
- improvement of assessment, diagnosis, and treatment of child abuse;
- newborn hearing screening reporting and tracking;
- evaluation of newborn hearing screening equipment; and
- follow-up for positive newborn screenings.

Amount of contracted expenditures in fiscal year 2012: $38,393,095
Number of program contracts: 326 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $3,025,306 | Sherry Matthews, Inc. | Public service announcements for THSteps |
| $1,806,627 | Optimization Zorn Corporation | Newborn hearing services |
| $1,683,058 | Office of the Attorney General | Rape prevention and education |

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $1,299,704 | Dallas County Hospital District | Prenatal health services |
| $1,014,039 | Ibn Sina Foundation, Inc. | Child health and dental services |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

DSHS awards grants in this program for the following services:

- prenatal care;
- preventive and primary child care;
- dental care for children and adolescents;
- comprehensive local system for health and well-being of youth;
- community health worker study;
- community-level, evidence-based interventions to decrease infant mortality and improve birth outcomes;
- curriculum for prenatal health care;
- policy development to support worksite breastfeeding;
- sexual violence prevention activities;
- assessments and evaluations;
- breast and cervical cancer screening, diagnosis, and referral;
- case management;
- client and healthcare professional education;
- internship program;
- improvement of assessment, diagnosis, and treatment of child abuse; and
- comprehensive genetic services to support newborn screening activities.

Using sub-recipient contracts, the program awards grants in the following manner:

- through competitive solicitations;
- through open enrollment;
- on an emergency or sole source basis when an approved emergency or sole source justification waives competition;

- to a state or local governmental entity through direct negotiation and grant contract execution to a state or local governmental entity (these entities are exempt from competition); and
- through a specific legislative mandate that requires DSHS to directly negotiate and execute a grant contract with a prescribed entity (MEDCARES – S.B. 2080, 81st Legislature, Regular Session, 2009).

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory changes to assist the program in performing its functions.

**Section 32.024(s)(2), Texas Human Resources Code** – The program recommends a revision to the statute to allow governmental entities and the three public dental schools to bill Medicaid for treatment or screening services provided without the parental accompaniment requirement. The revision would facilitate the provision of additional dental services without having to forego Medicaid reimbursement for the provision of those services.

**Section 37, Texas Health and Safety Code** – The program recommends repeal of this statute, which requires screening students in grades 6 and 9 in public and private schools for abnormal spinal curvature. The U.S. Preventive Services Task Force *Guide to Clinical Preventive Services, 2012,* recommends against screening for asymptomatic adolescents, as research has not found sufficient evidence to support that screening detects idiopathic scoliosis at an earlier stage.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

More information is available at the following program websites:
Breast and Cervical Cancer Services website: http://www.bccstexas.com
Case Management for Children and Pregnant Women website:
http://www.dshs.state.tx.us/caseman/default.shtm
Maternal and Child Health Fee-for-Service website: http://www.dshs.state.tx.us/mch/
Newborn Screening website: http://www.dshs.state.tx.us/newborn/default.shtm
Oral Health Program website: http://www.dshs.state.tx.us/dental/default.shtm
Spinal Screening website: http://www.dshs.state.tx.us/spinal/default.shtm
Texas Health Steps website: http://www.dshs.state.tx.us/thsteps/default.shtm
Vision and Hearing website: http://www.dshs.state.tx.us/vhs/default.shtm

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Family Planning Services |
| **Location/Division** | 1701 North Congress - Family and Community Health Services (FCHS) Division |
| **Contact Name** | Evelyn Delgado, Assistant Commissioner, FCHS Division |
| **Actual Expenditures, FY 2012** | $23,935,952 |
| **Number of Actual FTEs as of June 1, 2013** | 12.7 |
| **Statutory Citation for Program** | Senate Bill 1, 83rd Legislature, Regular Session, 2013, DSHS Riders 65 and 91 |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Family Planning Services has the primary objective to provide quality, comprehensive, low-cost, and easily accessible reproductive health care to women and men in order to reduce unintended pregnancies, improve health status, and positively affect future pregnancies.

Major activities of DSHS Family Planning Services include medical exams; laboratory tests; and provision of contraceptive methods, counseling, and education. Family Planning Services may also reimburse DSHS Family Planning contractors for infrastructure costs for family planning service delivery to clients. These allowable costs include salaries, supplies, equipment, travel, and professional development.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

DSHS Family Planning measures effectiveness by the number of clients served. In fiscal year 2012, DSHS Family Planning served 75,160 clients. DSHS Family Planning measures efficiency by average cost per client. The average cost per client in fiscal year 2012 was $237.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1990** – The Legislature, in the early 1990s, mandates that Title XX Family Planning services transfer from the former Texas Department of Human Services to the Texas Department of Health (TDH) to improve coordination of statewide Family Planning services. Title XX Family Planning is the only medical service funded under Title XX.

**2003-2004** – TDH Family Planning Program includes Medicaid Family Planning. Legislation in 2003 transfers Medicaid Family Planning, including the funds and performance targets, to HHSC. DSHS begins operations, and DSHS Family Planning continues to consult on family planning policy.

**2006** – With Legislative Budget Board approval, DSHS moves Title V Family Planning from Women and Children's Services budget strategy to Family Planning Services strategy.

**2011** – DSHS implements funding reductions resulting from the 82nd Legislature. DSHS pools remaining funds (Title X and Title XX) to create one funding source, and directs the majority of Title XX funds elsewhere in the state. DSHS rebrands the program as DSHS Family Planning, and DSHS Family Planning awards contractors one contract, as opposed to multiple contracts for different types of funding.

**2011** – The Legislature passes new requirements that require Family Planning funds to be allocated using a methodology that prioritizes distribution and reallocation first to public entities and Baylor College of Medicine clinics; second to non-public entities that provide comprehensive primary and preventive care; and, lastly, to non-public entities without comprehensive primary and preventive care.

**2013** – The Office of Population Affairs does not award DSHS Title X funds. Approximately half (19 of 37) of the current DSHS Family Planning contractors opt to continue receiving Title X funds through the new grantee. DSHS renews contracts with DSHS family planning entities with no other funding source. With the loss of Title X, DSHS contractors lose access to steeply discounted drug pricing through the federal 340B drug-pricing program. To mitigate the loss of Title X funds, DSHS Contingency Rider 91, S.B. 1, authorizes an appropriation of $16,057,982 in General Revenue funds for Family Planning in the 2014-15 biennium. In addition, DSHS Rider 96, S.B. 1, directs DSHS to locate improved pharmaceutical pricing or reduced pharmaceutical costs in order to address the loss of federal 340B drug pricing by DSHS family planning contractors. To comply with the rider, DSHS Family Planning creates a mechanism for the remaining family planning contractors to purchase discounted pharmaceuticals through the DSHS pharmacy.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

The target population for DSHS Family Planning Services is individuals seeking services who are low-income females of childbearing age and males without sterilization. Texas residents with income at or below 250 percent federal poverty level (FPL) are eligible.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The FCHS Division, Community Health Services Section, Primary and Preventive Care Unit administers the Family Planning Program. The Family Planning policy/procedure manual is available for review at http://www.dshs.state.tx.us/famplan/.

Contracted entities, such as local health departments (LHDs), FQHCs, universities, and other community-based agencies, deliver the family planning services. Program and contract support staff is located at DSHS central office in Austin and at the health service regional offices statewide. Central office staff develops Family Planning Program rules, policies, and procedures; and provide contract development, management, support, and oversight. Regional staff provides technical assistance and training to Family Planning contractors.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/fchs.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $23,437,971 |
| General Revenue | $425,326 |
| General Revenue-Dedicated | $0 |
| Other | $72,655 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| Primary Health Care | Family Planning and Primary Health Care both provide basic | In fiscal year 2014, Primary Health Care will serve clients up to 200 |

| Name | Similarities | Differences |
|---|---|---|
| | family planning services. | percent FPL, whereas Family Planning serves clients up to 250 percent FPL. |
| Breast and Cervical Cancer Services (BCCS) | Family Planning and BCCS both provide breast and cervical cancer screenings, such as pap smears and clinical breast exams. | BCCS uses 200 percent FPL for eligibility and covers diagnostic services and case management. Family Planning serves clients up to 250 percent FPL. |

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Medicaid (traditional) | Medicaid also provides family planning services. | Medicaid does not serve noncitizen population. |
| Texas Women's Health Program (TWHP) | TWHP also provides family planning services. | TWHP serves only women ages 18-44 and does not serve the noncitizen population. Some covered services differ between the two programs. For example, TWHP does not cover follow-up pap smears, pregnancy testing, and sexually transmitted disease testing-only visits. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

HHSC Medicaid and TWHP are statewide; however, their eligibility requirements are significantly different from the DSHS Family Planning Program. The eligibility determination process for each of the programs helps contractors and providers direct clients to the available and most appropriate services in their respective communities. DSHS promotes collaboration among contractors of all funding sources to minimize duplication of services. DSHS requires contractors to screen for TWHP eligibility, as well as other potential resources or programs that may serve clients, to ensure clients only utilize DSHS programs as safety net programs.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| LHDs and hospital districts | Local agencies that provide healthcare services to their respective constituents. | These entities contract with DSHS to provide family planning services. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Office of Family Assistance, Administration for Children and Families | The Office of Family Assistance is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. | The Office of Family Assistance is a Title XX grantor to DSHS. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts in this program for the following:

- medical exams,
- laboratory tests,
- provision of contraception,
- counseling, and
- education.

Amount of contracted expenditures in fiscal year 2012: $9,474,682
Number of program contracts: 186 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $1,069,057 | Planned Parenthood of Greater Texas, Inc. | Family planning services education and referral |
| $733,802 | University of Texas Medical Branch at Galveston | Family planning services education and referral |

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $696,005 | Dallas County Hospital District | Family planning services education and referral |
| $452,378 | Planned Parenthood Association of Hidalgo | Family planning services education and referral |
| $324,862 | Baylor College of Medicine | Family planning services education and referral |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

DSHS awards grants in this program for the following services:

- medical exams,
- laboratory tests,
- provision of contraception,
- counseling, and
- education.

Using sub-recipient contracts, the program awards grants in the following manner:

- through a specific legislative mandate that requires DSHS to directly negotiate and execute a grant contract with a prescribed entity or entities – 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013, (Article II, DSHS, Rider 65); and
- through competitive solicitations.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

Several riders attached to the appropriations bill each legislative session guide Family Planning Services. The 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, DSHS) has the following riders:

- Rider 17 prohibits DSHS from using state funds to pay for the direct and indirect costs of abortion procedures and prohibits DSHS from funding contractors that perform elective abortion procedures or that subcontract with or provide funds to individuals or entities that provide abortion procedures.
- Rider 18 prohibits the use of state funds to dispense prescription drugs to minors without parental consent.
- Rider 19 requires DSHS family planning services providers to comply with all child abuse reporting guidelines and requirements.
- Rider 23 prohibits distributing funds for medical, dental, psychological, or surgical treatment provided to a minor, unless providers obtain parental consent for these services. The Governor and the Legislative Budget Board may modify or suspend this requirement if compliance would result in the loss of federal funds to the state.
- Rider 50 outlines the legal requirements for a "family planning affiliate" and directs that an entity otherwise eligible to receive funds will not be disqualified because of its affiliation with an entity that performs elective abortions, provided that the affiliation meets certain requirements. The rider directs DSHS to conduct an annual audit of family planning services providers and directs HHSC to conduct an audit of each family planning affiliate every two years.
- Rider 65 requires Family Planning funds to be allocated using a methodology that prioritizes distribution and reallocation first to public entities that provide family planning services, including state, county, local community health clinics, federally qualified health clinics, and clinics under the Baylor College of Medicine; second to non-public entities that provide comprehensive primary and preventive care as a part of their family planning services; and third to non-public entities that provide family planning services, but do not provide comprehensive primary and preventive care. Up to $1,000,000 per year may be awarded to Baylor College of Medicine.
- Rider 91 provides contingency funds from General Revenue in the case of the loss of Title X funding and prohibits DSHS from contracting with any providers that would be ineligible to participate in the TWHP.
- Rider 96 requires DSHS to attempt to locate improved pharmaceutical pricing or reduced pharmaceutical costs to address the loss of 340B drug pricing for family planning providers.
- HHSC Special Provisions, Section 51, provides for the transfer of remaining funds in the TWHP to DSHS Family Planning in the instance that TWHP is directed to cease operations.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**

- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS – CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Primary Health Care Services |
| **Location/Division** | 1701 North Congress - Family and Community Health Services (FCHS) Division |
| **Contact Name** | Evelyn Delgado, Assistant Commissioner, FCHS Division |
| **Actual Expenditures, FY 2012** | $14,207,006 |
| **Number of Actual FTEs as of June 1, 2013** | 16.0 |
| **Statutory Citation for Program** | Chapter 31, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Primary Health Care (PHC) has as its primary objective to develop and support primary healthcare and nutrition services to children, women, families, and other qualified individuals through community-based providers.

The PHC Program provides prevention-oriented, education-based primary healthcare services to Texas residents unable to access the same care through other funding sources or programs. The following basic healthcare services are priority services for PHC:

- diagnosis and treatment;
- emergency services;
- family planning services;
- preventive health services, including immunizations;
- health education; and
- laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services.

The 83rd Legislature, Regular Session, 2013, appropriated funds for the expansion of women's primary and preventive services through PHC Program. The expansion of the program will allow DSHS to provide additional services, including:

- breast and cervical screening;
- prenatal medical and dental services;
- an emphasis on family planning services, including contraception; and
- comprehensive treatment of chronic conditions, such as high blood pressure and high cholesterol.

The expansion also allows DSHS to incentivize the use of community health workers to provide outreach and direct women to services indicated, as necessary, through screening visits.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

The PHC Program uses key statistics and performance measures to evaluate program effectiveness and efficiency. In addition to the Legislative Budget Board performance measures, state statute mandates the following information in annual reports to the Legislature.

| **Primary Health Care Program – Fiscal Year 2012** | |
|---|---|
| **Health Service Region** | **Number Clients Served** |
| HSR 1 | 17,072 |
| HSR 2/3 | 9,087 |
| HSR 4/5N | 10,805 |
| HSR 6/5S | 12,755 |
| HSR7 | 3,184 |
| HSR 8 | 4,736 |
| HSR 9/10 | 8,807 |
| HSR 11 | 7,892 |
| **Total** | **64,338** |
| **Total Cost for Each Service Authorized Under the Law** | |
| **Service** | **Amount** |
| Emergency Services | $227 |
| Nutrition | $24,363 |
| Transportation | $87,804 |
| Screening and Eligibility | $89,331 |
| Family Planning | $129,936 |
| Other Optional Services | $222,748 |
| Counseling/Case Management/Social Services | $302,238 |
| Dental Services | $451,296 |
| Pharmacy | $475,659 |
| Health Education | $529,025 |
| Preventive Health | $585,872 |

| Service | Amount |
|---|---|
| Laboratory/X-ray/Other Diagnostic Tests | $1,781,980 |
| Diagnosis and Treatment | $5,636,918 |
| **Total Administrative Costs of Program** | **$1,435,089** |
| **Total Cost of Program** | **$11,752,486** |
| Source: DSHS calculated regional expenditures by applying regional percentages from the contractor-reported client numbers in the PHC FY 2012 Annual Report to the total number of clients served as reported in the FY 2012 Key Performance Measures. The total cost for each service authorized under law is from the PHC FY 2012 Annual Report. | |

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1980** – During the early 1980s, economic recession and cost containment measures on the part of employers and government agencies led to a decrease in the availability and accessibility of healthcare services for many Texans. A gubernatorial and legislative task force identified the provision of primary health care to the medically indigent as a major priority. The task force recommended the following.

- The medically indigent residing in Texas should have access to a range of primary healthcare services.
- The former Texas Department of Health (TDH), now known as DSHS, should provide or contract to provide primary healthcare services to the medically indigent. These services should complement existing services and/or TDH should provide the services where scarce.
- TDH should ensure that health education is an integral component of all primary care services delivered to the medically indigent population. TDH should market preventive services and make them accessible, to reduce the use of more expensive emergency room services.

These recommendations became the basis of the indigent healthcare legislative package implemented as part of the Primary Health Care Services Act, Chapter 31, Texas Health and Safety Code, which is the statutory authority for the PHC Program administered by DSHS. The act delineates the specific target population, eligibility, reporting, and coordination requirements for PHC.

**2013** – The Legislature approved DSHS' exceptional item request to expand women's preventive and primary care through the PHC Program. The expanded PHC Program will serve women age 18 and above and increase eligibility from 150 FPL to 200 percent FPL.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

The population eligible for the PHC Program is Texas residents at or below 150 percent FPL who do not have access to other programs or resources providing similar benefits. In fiscal year 2014, PHC will serve clients up to 200 percent FPL. In fiscal year 2012, 59 PHC contractors provided basic healthcare services to 64,338 unduplicated clients (72 percent female and 28 percent male; 67 percent Hispanic and 33 percent non-Hispanic; 4 percent 0-17 years, 93 percent 18-64 years, and 3 percent 65 years and older).

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The FCHS Services Division, Community Health Services Section, Primary and Preventive Care Unit administers the PHC Program. The PHC policy/procedure manual is available for review at: http://www.dshs.state.tx.us/phc/pandp.shtm.

Contracted entities such as local health departments (LHDs), federally qualified health centers, hospital districts, universities, and community-based organizations deliver PHC services. Program and contract support staff is located at DSHS central office in Austin and at the HSR offices statewide. Central office staff is responsible for administering the PHC Program; collecting data, as required by statute; developing PHC rules, policies, and procedures; and providing contract development, management, support, and oversight. HSR staff provides technical assistance and training to PHC contractors, and, in the case of HSR 9/10, staff directly provides PHC services.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/fchs.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $688,893 |
| General Revenue | $13,448,723 |
| General Revenue-Dedicated | $69,390 |
| Other | $0 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| Texas Health Steps (THSteps) | PHC Program and THSteps both cover child health benefits. | THSteps provides services to Medicaid-eligible children, whereas PHC will provide service to children not eligible for Medicaid up to 200 percent FPL in fiscal year 2014. |
| Oral Health Program (OHP) | PHC Program and OHP both provide dental benefits to low-income children. | OHP limits services for low-income children to sealants, whereas PHC services provide basic dental care, such as fillings, cleanings, and extractions. |
| DSHS Family Planning Services | PHC Program and Family Planning Services both cover family planning benefits. | PHC will serve up to 200 percent FPL, whereas DSHS Family Planning serves up to 250 percent FPL. Family planning services are limited in scope, whereas PHC services cover a broader array of services. |
| Breast and Cervical Cancer Services (BCCS) | PHC Program and BCCS both provide basic screenings for breast and cervical cancer such as a clinical breast exams and pap smears. | BCCS provides a wider range of breast and cervical cancer screening and diagnosis services for clients up to 200 percent FPL. BCCS services are limited in scope, whereas PHC services cover a broader array of services. |
| County Indigent Health Care Program (CIHCP) | PHC Program and CIHCP both provide primary healthcare benefits. | PHC will serve up to 200 percent FPL in fiscal year 2014, whereas CIHCP serves residents of certain counties whose incomes are at or below 21 percent FPL and who are not eligible for Medicaid. Counties may choose to increase the monthly income standard to a maximum of 50 percent FPL. |

| Name | Similarities | Differences |
|---|---|---|
| Title V Maternal and Child Health (Title V MCH) | PHC Program and Title V MCH both provide maternal and child health benefits. | PHC will serve up to 200 percent FPL, whereas Title V serves up to 185 percent FPL. Title V MCH services are limited in scope, whereas PHC services cover a broader array of services. |

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Medicaid | PHC Program and Medicaid both provide similar primary healthcare services. | Medicaid serves a Medicaid-eligible population whereas PHC will serve non-Medicaid eligible people up to 200 percent FPL. |
| Children's Health Insurance Program (CHIP) | PHC Program and CHIP both provide similar child health services. | CHIP serves CHIP-eligible children whereas PHC will serve non-CHIP eligible children up to 200 percent FPL. |
| Texas Women's Health Program (TWHP) | PHC Program and TWHP both provide women's health-related benefits. | TWHP serves only Medicaid waiver eligible women ages 18-44. TWHP services are limited to family planning services whereas PHC services cover a broader array of services. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

The eligibility determination process for the PHC Program helps contractors and providers direct clients to the available and most appropriate services in their respective communities. DSHS promotes collaboration among contractors of all funding sources to minimize duplication of services. Annual meetings attended by all Community Health Services contractors provide a forum for contractors to discuss and implement collaborative service delivery plans. DSHS requires contractors to identify other potential resources or programs that may serve clients to ensure that clients only use DSHS programs as safety net programs.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| LHDs, public hospitals, and hospital districts | These entities are local agencies that provide healthcare services to their respective constituents. | These entities contract with DSHS to provide PHC services. |
| County-run indigent healthcare programs | These programs are local services provided to eligible county residents in counties (or areas of counties) not covered by a public hospital or hospital district. | County-run indigent healthcare programs coordinate services with PHC contractors in order to serve clients efficiently. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts in this program for the following:

- diagnosis and treatment;
- emergency services;
- family planning services
- preventive health services, including immunizations;
- health education; and
- laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services.

Amount of contracted expenditures in fiscal year 2012: $12,454,573
Number of program contracts: 59 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $700,000 | Community Action Corporation of South Texas | Health care to eligible low-income individuals |
| $517,354 | North Central Texas Community Health Care | Health care to eligible low-income individuals |
| $450,723 | Fort Bend Family Health Center, Inc. | Health care to eligible low-income individuals |

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $401,801 | Brazos Valley Community Action Agency | Health care to eligible low-income individuals |
| $382,249 | South Plains Rural Health Services, Inc. | Health care to eligible low-income individuals |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

DSHS awards grants in this program for the following services:

- diagnosis and treatment;
- emergency services;
- family planning services;
- preventive health services, including immunizations;
- health education; and
- laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services.

Using sub-recipient contracts, the program awards grants in the following manner:

- through a specific legislative mandate that requires DSHS to directly negotiate and execute a grant contract with a prescribed entity or entities – 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013, (Article II, DSHS, Rider 62); and
- through competitive solicitations.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

More information is available at the program website for PHC Services:
http://www.dshs.state.tx.us/phc/

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Specialized Health Services |
| **Location/Division** | 1701 North Congress - Family and Community Health Services (FCHS) Division |
| **Contact Name** | Evelyn Delgado, Assistant Commissioner, FCHS Division |
| **Actual Expenditures, FY 2012** | $59,917,025 |
| **Number of Actual FTEs as of June 1, 2013** | 148.4 |
| **Statutory Citation for Program** | Chapter 35, 41, and 42, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Specialized Health Services has the following primary objectives.

- Use health promotion for reducing the prevalence of preventable chronic diseases and injury.
- Administer service care programs related to certain chronic health conditions.

Major activities include the following.

**Children with Special Health Care Needs (CSHCN) Services Program**

The CSHCN Services Program provides eligible children with early identification, diagnosis and evaluation, and rehabilitation services. Medical services include inpatient and outpatient care, physician services, therapies, durable medical equipment and supplies, drugs, home health, skilled nursing, lab, radiology, and dental services. The CSHCN Services Program is not an entitlement program. Due to budgetary limitations, the program has a waiting list.

The CSHCN Services Program staff provides information and referral, completes family needs assessments, develops individual service plans, coordinates services, marshals available assistance, and serves as a liaison between the child and the child's family and various service providers. Through these activities, the program seeks to attain services needed to improve the well-being of the child and the child's family.

Enabling services provide access to healthcare benefits, such as assistance with private insurance (premiums and co-pays), meals, lodging, and transportation. Family support services include disability-related support, resources, or assistance to families with children eligible for the CSHCN Services Program, such as respite care, minor home modifications, and van lifts. Infrastructure building services facilitate the development of effective service delivery systems

for children with special healthcare needs. Program services include needs assessment, evaluation, policy and service system development and coordination, and promoting standards of care and quality assurance.

**Epilepsy Services**

Epilepsy Services provides services to persons who have epilepsy and/or seizure-like symptoms. The statewide program contracts with nonprofit and governmental entities to provide comprehensive outpatient care, including medical and non-medical services, for persons with epilepsy or seizure disorders. Contractors may subcontract with neurologists and epileptologists to provide clinical services such as diagnostic tests, including electroencephalograms (EEGs) and magnetic resonance imaging (MRIs), prescription medications, and medication management of the patient. Contractors provide outpatient care, including non-clinical services such as case management, counseling, health education, referral services, and community outreach. The program also provides information and referral to providers for services such as transportation, mental health, dental, patient assistance, and prescription medication programs.

**Hemophilia Assistance Program (HAP)**

HAP provides limited financial assistance to persons diagnosed with hemophilia who meet eligibility requirements for blood derivatives, blood concentrates, and manufactured pharmaceutical products through program-approved providers.

**Kidney Health Care (KHC) Program**

The KHC Program provides limited assistance to, or on behalf of, individuals with end-stage renal disease (ESRD), the final and most severe stage of renal impairment. ESRD is usually irreversible and requires dialysis and/or kidney transplant to reduce uremic symptoms (characterized by a buildup of nitrogen waste products) and/or prevent death.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

Specialized Health Services uses the following measures to evaluate the effectiveness and efficiency of program activities:

- average monthly caseload of CSHCN clients receiving healthcare benefits;
- average monthly cost per CSHCN client receiving healthcare benefits;
- number of CSHCN clients provided healthcare benefits at end of year;
- number of KHC clients provided services;
- average cost per chronic disease for KHC clients;
- number of Hemophilia Assistance Program clients provided services; and
- number of Epilepsy Program clients provided services.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1999** – Senate Bill 374 renames CSHCN Services and expands program medical eligibility criteria from diagnosis-specific to a broader, functional definition of a child with special healthcare needs. In addition, the Senate bill also makes the program healthcare benefits comprehensive. The Texas Department of Health implemented these changes in July 2001.

**2001** – The CSHCN Services Program implements a waiting list. The program removes clients from the waiting list in priority order as funds become available.

**2013** – Senate Bill 1815 amends Section 692A, Texas Health and Safety Code to remove the responsibility of administering the Glenda Dawson Donate Life - Texas Registry from DSHS.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

**Children with Special Health Care Needs Services Program**
Eligibility criteria include:

- age younger than 21 years and a chronic physical or developmental condition that is expected to last a minimum of 12 months; or cystic fibrosis, regardless of age;
- Texas resident;
- family income at or below 200 percent federal poverty level (FPL); and
- renews eligibility annually.

In fiscal year 2012, the CSHCN Services Program determined 1,926 persons eligible to receive services and served 1,906 of those deemed eligible. Of those served, 81 percent were Hispanic, approximately 18 percent were White and/or Other, and less than one percent were Black. In fiscal year 2012, regional staff and CSHCN Services Program contractors provided case management services to 4,562 children with special healthcare needs, including those with Medicaid. In fiscal year 2012, CSHCN Services Program contractors provided respite or other family support services for 2,091 children with special healthcare needs and their families.

**Epilepsy Services**
Eligibility criteria include:

- age younger than 21 years and ineligible for benefits from the CSHCN Services Program;
- income level 200 percent or below FPL,
- Texas resident,
- presence of seizures or related symptoms; and
- ineligible for other programs or services.

An individual on the CSHCN Services Program waiting list can receive services until accepted into the CSHCN Services Program.

In fiscal year 2012, five Epilepsy Services contractors provided services to 8,876 unduplicated clients.

**Hemophilia Assistance Program**
Eligibility criteria include:
- age of 21 years or older;
- income level at or below 200 percent FPL;
- Texas resident;
- diagnosis of hemophilia;
- uninsured or underinsured status and ineligible for other publicly funded programs; and
- ineligible for Medicare or Medicaid benefits.

In fiscal year 2012, seven clients received benefits.

**Kidney Health Care Program**
Eligibility criteria include:
- diagnosis of ESRD;
- Texas resident;
- submits an application for benefits through a participating facility;
- receives a regular course of chronic renal dialysis treatments or a kidney transplant;
- meets Medicare criteria for ESRD met;
- ineligible for full Medicaid benefits (medical, drug, or travel benefits); and
- income of less than $60,000 per year.

In fiscal year 2012, the KHC Program provided benefits to 19,375 active recipients. (The program defines active recipients as those people who received any program benefits.) Of active recipients, approximately 44 percent were Hispanic, 29 percent were Black, and 27 percent were White and/or Other. Also in fiscal year 2012, the KHC Program approved 3,552 new program beneficiaries. (The program defines approved applicants as those people with ESRD who became newly eligible for KHC Program benefits.)

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The FCHS Division, Specialized Health Services Section, Purchased Health Services Unit administers the CSHCN Services Program, KHC Program, and HAP. The CSHCN Services Program is a comprehensive health benefits program while the KHC Program and HAP provide limited

benefits. The FCHS Division, Community Health Services Section, Primary and Preventive Care Unit administers the Epilepsy Program, which also provides limited benefits.

The CSHCN Services Program supports case management services across Texas through the DSHS regional offices, as well as through community-based contractors, including nonprofit organizations, local health departments, hospitals, and university-based programs. Additionally, contracted services provide clinical services, family support, and referrals to community resources. The CSHCN Program's client handbook is located at: http://www.tmhp.com/TMHP_File_Library/CSHCN/CSHCN%20Client%20Handbook/2007-CSHCN-Client-Handbook_English.pdf. The provider manual is located on the Texas Medicaid and Healthcare Partnership website at: http://www.tmhp.com/Pages/CSHCN/CSHCN_Publications_Provider_Manual.aspx.

Contracted providers provide Epilepsy, HAP, and KHC services. Epilepsy Services program and contract support staff are located at DSHS central office in Austin and at DSHS regional offices statewide. Five DSHS contractors provide the services to clients. DSHS central office staff is responsible for administrating the collection of data; developing program rules, policies, and procedures; and providing contract development, management, support, and oversight. The Epilepsy Services policy/procedure manual is available at: http://www.dshs.state.tx.us/epilepsy/pol_man.shtm.

HAP contractors (hemophilia treatment centers and home care agencies) receive prior authorization to ship blood factor as prescribed by the physician to the client. The program provides benefits for blood products to approved HAP recipients on a first-come, first-served basis, as long as funds are available. Potential clients submit applications by mail or fax directly to HAP for eligibility determination.

The KHC Program contracts with dialysis, hospital, and physician providers throughout the state. The KHC Program's automated system determines client eligibility and processes travel and medical claims. Contracted providers submit applications for eligibility and the Medicaid Vendor Drug Program contractor processes drug claims. The KHC Program has a recipient's handbook found at: http://www.dshs.state.tx.us/kidney/pdf/recipienthandbook2006.pdf.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/fchs.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $11,373,684 |
| General Revenue | $48,168,986 |
| General Revenue-Dedicated | $0 |
| Other | $374,355 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Children with Special Health Care Needs Services Program - Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| Case Management for Children and Pregnant Women | The same DSHS staff provides case management services through the CSHCN Services Program and Case Management for Children and Pregnant Women. | Medicaid Case Management for Children and Pregnant Women is an entitlement program, and CSHCN Services Program case management is not. Case Management for Children and Pregnant Women covers pregnant women with high risks, and CSHCN Services Program case management does not. |

**Children with Special Health Care Needs Services Program - External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Children's Health Insurance Program (CHIP) | CSHCN Services Program and CHIP both provide healthcare benefits to children. | CHIP does not provide family support services or a transportation benefit. CHIP does not assume lead responsibility for facilitating Title V systems development for children and youth with special healthcare needs. Specialized Health Services may not use Title V funds to pay for services available through CHIP. |
| Medicaid | CSHCN Services Program and Medicaid both provide healthcare benefits and case management services. | Medicaid does not provide family support services (see "Medicaid waiver programs" below). There are certain differences in eligibility criteria for healthcare benefits, and Medicaid is an |

| Name | Similarities | Differences |
|---|---|---|
| | | entitlement program. Medicaid does not assume lead responsibility for facilitating Title V systems development for children and youth with special healthcare needs. Specialized Health Services may not use Title V funds to pay for services for children eligible for Medicaid. |
| Medicaid waiver programs | CSHCN Services Program and Medicaid waiver programs both provide family support services. | Children receiving services through a Medicaid waiver program are not eligible for family support services through the CSHCN Services Program healthcare benefits. There are some differences in scope and array of family support services for CSHCN and Medicaid waiver programs. |
| In-home Family Supports, Department of Aging and Disability Services | CSHCN Services Program and In-home Family Supports both provide limited family support services. | The CSHCN Services Program family support services may supplement but not duplicate In-home Family Supports. There are some differences in scope and array of family support services for CSHCN and In-home Family Supports. |

**Epilepsy Services - Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| CSHCN Services Program | CSHCN Services Program and Epilepsy Services both provide epilepsy services until the age of 21. | CSHCN Services Program does not provide services to adults over 21. The Epilepsy Services Program primarily serves adults, but also serves children that are not eligible for CSHCN. |

**Epilepsy Services - External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Early Childhood Intervention (ECI) Services, Department of Assistive and Rehabilitative Services | Epilepsy and ECI Services both provide epilepsy services, depending on the individual needs of the child, such as assistive technology; audiology; developmental services; family counseling; nutrition education; occupation, physical, and speech therapies; psychological and social work; and vision services. | ECI Services only provides services for children up to the age of three. Families with children enrolled in Medicaid or CHIP, or whose income is below 250 percent FPL, do not pay for any ECI services. Epilepsy Services determine client co-pays according to a sliding fee scale based on family size and net income after allowable deductions. Epilepsy Services income eligibility is 200 percent or below FPL. |

**Hemophilia Assistance Program - Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| CSHCN Services Program | HAP and CSHCN Services Program provide coverage for blood factor products. | CSHCN provides coverage for a different age group (up to 21 years old) and full healthcare benefits. HAP provides coverage for 21 years or older and limited benefits. |

**Hemophilia Assistance Program - External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Medicaid | HAP and Medicaid both provide coverage for blood factor products. | The FPL coverage levels are different for both children and adults in HAP and Medicaid. The range of provided healthcare benefits is also different. |
| CHIP | HAP and CHIP both provide coverage for blood factor products. | CHIP provides coverage up to age 21 and a range of healthcare benefits. HAP provides coverage for 21 years or older and limited benefits. |
| Pre-Existing Condition Insurance Plan: Texas (PCIP) | HAP and PCIP both provide coverage for blood factor products. | PCIP provides a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. However, PCIP requires that clients have |

| Name | Similarities | Differences |
|---|---|---|
| | | been uninsured for at least the last six months before they may apply. HAP provides limited benefits. |

**Kidney Health Care Program - External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Medicaid | KHC Program and Medicaid both provide medical benefits, drug benefits, and travel benefits. | If eligible for Medicaid, individuals are not eligible for KHC. |
| Medicare Parts B and D | KHC Program and Medicare Parts B and D both provide prescription drug coverage. | Medicare has coverage limitations, including deductibles, premiums, and the donut hole gap. KHC Program is secondary payer to Medicare for drug benefits. |
| Medicare Parts A and B | KHC Program and Medicare Parts A and B both provide medical benefits. | Individuals eligible for Medicare A and B are not eligible for KHC Program medical benefits. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

The CSHCN Services Program coordinates with other state programs serving children with disabilities through participation in such forums as the Texas Council for Developmental Disabilities, Texas Interagency Council on Early Childhood Intervention, Children's Policy Council, Promoting Independence Advisory Committee, Money Follows the Person Demonstration Project, Consumer Direction Workgroup, and Texas Integrated Funding Initiative.

The CSHCN Services Program obtains eligibility information from CHIP and Medicaid on applicants for the CSHCN Services Program healthcare benefits, since applicants are to access all available insurance before using these benefits. The KHC Program shares data enrollment information with Medicaid and Medicare Part D. The KHC Program does not exchange Part A or B data with Medicare. Medicare files identifying Part D clients indicate those clients having Medicare Part A, Part B, or both. HAP screens for Medicaid eligibility using the Medicaid System for Application, Verification, Eligibility, Referrals, and Reporting system and the Texas Integrated Eligibility Redesign System.

On July 1, 2010, U.S. Department of Health and Human Services opened enrollment to eligible residents of Texas for coverage through the state's PCIP program. PCIP covers a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs, even if used to treat a pre-existing condition. Eligibility criteria require that clients are uninsured for at least six months before they apply. PCIP does not consider HAP "creditable coverage" under the law; therefore, HAP clients are potentially eligible for PCIP.

The eligibility determination process for Epilepsy Services helps contractors and providers direct clients to the available and most appropriate services in their respective communities. DSHS promotes collaboration among contractors of all funding sources to minimize duplication of services. DSHS requires contractors to identify other potential resources or programs that may serve clients to minimize duplication and to ensure that clients only use Epilepsy Services as a safety net program.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Children with Special Health Care Needs Services Program - Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Cameron County Department of Health and Human Services, Harris County Hospital District, Jasper-Newton County Public Health District, and Williamson County and Cities Health District | These four local units of government are local public health agencies that provide healthcare services to their respective areas. | The four local units of government are contracted providers to the CSHCN Services Program for case management services to children and youth with special healthcare needs. |

**Children with Special Health Care Needs Services Program - Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Maternal and Child Health Bureau | The federal Maternal and Child Health Services programs provide a foundation and structure for assuring the health of American mothers and children. | The CSHCN Services Program submits reports, plans, and needs assessment information to the Maternal and Child Health Bureau annually in the Title V application. |

**Epilepsy Services - Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Dallas County Hospital District | Dallas County Hospital District is a public hospital district with seven clinics, serving Dallas and surrounding counties. | Dallas County Hospital District contracts with DSHS to provide epilepsy services. |
| Harris County Hospital District | The Harris County Hospital District is a public hospital district with one clinic, serving one county. | The Harris County Hospital District contracts with DSHS to provide epilepsy services. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts with nonprofit and governmental entities in this program to perform the services described below:

- actuarial consulting services provided to Children with Special Health Care Needs Services Program and Texas Human Immunodeficiency Virus (HIV) Medication Program;
- kidney dialysis, access surgery, and limited hospitalization services;
- hemophilia blood factor, respite care services, and Medicare Part D premium providers;
- diagnosis and treatment for medical condition;
- case management system for continuity of care;
- integration of personal, social, and vocational support services; and
- public awareness and educational services.

Amount of contracted expenditures in fiscal year 2012: $3,853,300
Number of program contracts: 1,000 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $623,496 | Epilepsy Foundation of Texas | Outpatient epilepsy services |
| $576,019 | United Healthcare Insurance Company | Kidney health services |
| $359,776 | Coalition of Health Services, Inc. | Case management services |

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $354,000 | Any Baby Can of San Antonio, Inc. | Case management services |
| $298,249 | Epilepsy Foundation of Central and South Texas | Outpatient epilepsy services |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

DSHS awards grants in this program for the following services:

- case management services;
- comprehensive outpatient services for coordination of care at a community clinic site to children under 21 years old;
- family support and community resources services to or on behalf of individuals who are under 21 years old;
- training program to build capacity to improve transition services and processes for youth and young adults with special healthcare needs and their families;
- diagnosis and treatment for epilepsy;
- case management system for continuity of care;
- integration of personal, social, and vocational support services; and
- public awareness and educational services.

Using sub-recipient contracts, the program awards grants in the following manner:

- through competitive solicitation, and
- through open enrollment process.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N . Provide any additional information needed to gain a preliminary understanding of the program or function.**

The CSHCN Services Program provides clients with comprehensive healthcare benefits, along with case management, family support, and community resource services. All General Revenue dollars for Epilepsy Services are in contracts for direct client services; the program does not use funds for administrative costs. Both the KHC Program and HAP provide limited benefits to ease the financial burden of obtaining essential medical treatment. The KHC Program provides limited financial assistance to Texas residents with ESRD who are approved for KHC benefits; HAP helps people with hemophilia pay for their blood factor products.

More information is available at the following program websites:
CSHCN Services Program: http://www.dshs.state.tx.us/cshcn/default.shtm
Epilepsy Services: http://www.dshs.state.tx.us/epilepsy/
HAP: http://www.dshs.state.tx.us/hemophilia/default.shtm
KHC Program: http://www.dshs.state.tx.us/kidney/default.shtm

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS – CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Nutrition Services and Obesity Prevention |
| **Location/Division** | 4616 West Howard Lane, Suite 840, Austin - Family and Community Health Services (FCHS) Division;<br>1100 W. 49th Street, Austin - Disease Control and Prevention Services (DCP) Services Division |
| **Contact Name** | Evelyn Delgado, Assistant Commissioner, FCHS Division;<br>Janna Zumbrun, Assistant Commissioner, DCP Services Division |
| **Actual Expenditures, FY 2012** | $755,301,635 |
| **Number of Actual FTEs as of June 1, 2013** | 239.7 |
| **Statutory Citation for Program** | 42 U.S.C. 1786, Child Nutrition Act of 1966, as amended, Section 17; Public Law 111-296, 7 U.S.C. 1746, Healthy, Hunger-Free Kids Act of 2010 |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

The Nutrition Services and Obesity Prevention (NSOP) Program has as its primary objective to develop and support nutrition services to qualified individuals including children, women, and families, though community-based providers. Major activities include the following.

**Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)**
WIC provides nutrition services to eligible low-income pregnant, postpartum, and breastfeeding women; infants; and children under age five. Services include breastfeeding promotion and support (including provision of breast pumps), nutrition education and counseling, referrals to other health and human services, and provision of healthy nutritious foods (including infant formula).

**Nutrition, Physical Activity and Obesity Prevention (NPAOP) Program**
The NPAOP Program works to reduce the burden of death and disease related to overweight and obesity through evidence-based, community interventions that promote policy and environmental changes in order to make healthy eating and physical activity the easy choice for individuals. NPAOP provides activities to communities and statewide populations with no requirements for eligibility. The program funds 19 community-based obesity prevention

activities to accomplish the outcomes described below.

- Increase physical activity, consumption of fruits and vegetables, and breastfeeding.
- Decrease television viewing, consumption of sugar-sweetened beverages, and consumption of high-energy dense foods (high calorie/low nutrient foods).

Community-based obesity prevention activities include:

- coalition building – facilitates state and local coalitions to promote nutrition and physical activity;
- partnerships – collaborates with state and local partners to plan, implement, and evaluate community-based nutrition and physical activity interventions; and
- training, consultation, and technical assistance – provides nutrition training and consultation; and technical assistance to health and human service professionals in agencies and organizations such as local health departments (LHDs), schools, daycare facilities, Head Start, community health agencies, and worksites.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

Key statistics and performance measures show the effectiveness and efficiency of NSOP activities.

**Special Supplemental Nutrition Program for Women, Infants, and Children**

WIC utilizes statewide performance measures to analyze the effectiveness and efficiency of the program. For example, WIC measures the average food cost per person of supplemental allowable foods purchased as part of the services to eligible WIC program participants. The target goal for fiscal year 2012 was $30.50. The actual average food cost per person in fiscal year 2012 was $29.25.

WIC requires contractors who provide WIC services to submit performance measures, such as the following:

- number of nutrition education encounters provided,
- percent of WIC participants who indicate that they have no source of health care that are referred to a healthcare source, and
- percent of WIC participants who are enrolled and receive WIC benefits each quarter.

**Nutrition, Physical Activity and Obesity Prevention Program**

The NPAOP Program evaluates progress toward performance measures through:

- annual surveys, such as the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, community point-in-time surveys related to nutrition and physical activity, and internal partner and stakeholder surveys; and

- staff and contractor reports generated through the Program Monitoring and Tracking system.

NPAOP organizes evaluation data on progress and subsequent recommendations into a strategic plan for stakeholders, partners, and communities to use as a guide for planning activities and implementing nutrition and physical activity-related interventions. The goal of interventions is to impact and improve health status in the populations served.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1989** – Public Law 101-147 requires the state WIC to use a competitive bidding system to secure rebates on the purchase of infant formula. Today, rebates from the contracted formula company provide 26 percent of WIC funding, approximately $210,000,000.

**1998** – Congress authorizes WIC to utilize food funds for breast pumps. Congress had not previously authorized the use of funds from the food dollars for anything other than foods. Since initiation of the breast pump program, breastfeeding rates increase from 54 percent to 76.6 percent.

**2001** – DSHS implements the School Physical Activity and Nutrition (SPAN I-II) Survey, the first such surveillance conducted on a representative statewide sample of 4$^{th}$-, 8$^{th}$-, and 11$^{th}$-graders in the nation.

**2003** – The legacy Texas Department of Health and other agencies form the Goal A workgroup to direct and advise statewide activities through a strategic action plan for the prevention and control of obesity and related chronic diseases. The plan includes nutrition-related services, and educational and training efforts to improve nutrition health status as it relates to obesity prevention. In 2005, the workgroup updates the evaluation methods and refines indicators to improve the tracking of progress at the state level.

**2004** – DSHS conducts the SPAN III survey in 2004-2005 to repeat and compare the measures of nutrition, physical activity, and weight status in Texas schoolchildren.

**2004** – DSHS successfully pilots an Electronic Benefits Transfer (EBT) food delivery system to replace WIC paper food vouchers, followed by federal and state approvals to implement the system statewide. EBT is more convenient for WIC participants and offers a more efficient payment of vendors. Statewide implementation occurs in April 2009.

**2004** – As part of the 2004 WIC reauthorization, Congress expands the definition of WIC nutrition education to include education designed to achieve positive changes in physical activity

habits. Congress makes the revision recognizing that successful efforts to reduce overweight and obesity require both nutrition and activity education.

**2007** – U.S. Department of Agriculture (USDA) develops a new interactive participatory approach to nutrition assessment called Value Enhanced Nutrition Assessment (VENA). The VENA philosophy improves nutrition services in WIC by establishing standards for the assessment process used to determine WIC eligibility and to individualize nutrition education, referrals, and food package tailoring. DSHS WIC implements VENA in October 2007.

**2009** – DSHS WIC implements a USDA interim final rule revising the WIC food packages. Revisions include less milk and cheese offered overall with reduced fat milk required for all clients over age two; fruits and vegetables; new whole grain foods such as bread, tortillas, and brown rice; jarred infant foods; and incentives for breastfeeding mothers.

**2012** – DSHS WIC ceases to administer the Farmers' Market Nutrition Program (FMNP), due to funding constraints. FMNP provides fresh fruits and vegetables to WIC clients and promotes the use and awareness of local farmers' markets. The Texas Department of Agriculture (TDA) now administers FMNP.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

**Special Supplemental Nutrition Program for Women, Infants, and Children**
WIC serves low-income pregnant, postpartum, and breastfeeding women; infants; and children under age five who live in Texas and are at nutrition risk as determined by a health professional. Income must be at or below 185 percent FPL. A person who participates or has family members who participate in Medicaid, Supplemental Nutrition Assistance Program, and/or Temporary Assistance for Needy Families automatically meets the income eligibility requirement.

WIC is serving an average of 960,000 clients monthly in fiscal year 2013, with approximately 60 percent of the infants born in Texas participating in WIC. An estimated 1.4 million Texans are potentially eligible for services.

**Nutrition, Physical Activity and Obesity Prevention Program**
Services affect general community and statewide population groups with no requirements for qualifying or eligibility. In cooperation with the University of Texas, School of Public Health at Houston, the School Physical Activity and Nutrition Survey Project has collected data to monitor the nutritional health status of Texas children since 2004.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

**Special Supplemental Nutrition Program for Women, Infants, and Children**

The FCHS Division, Nutrition Services Section administers the WIC program. The Nutrition Services Section formulates, implements, and monitors all rules, policies, and business decisions concerning the program. Nutrition Services staff has authority to deal directly with the federal grantor, the USDA, and completes and submits the federally required annual State Plans of Operations and required financial reports. The Nutrition Services Section ensures compliance with the financial, administrative, and programmatic aspects of the program, especially through its contracts with local service providers. Budget oversight of what allowable and reasonable expenditure, both central and local, is a key responsibility of Nutrition Services staff.

Nonprofit local agencies under contract to DSHS are the primary providers of WIC direct client services. Local agencies include LHDs and health districts, community action agencies, hospitals, state universities, and city and county governments. In the past, four DSHS health service regions (HSRs) performed as local agencies and provided WIC services. In fiscal year 2013, DSHS outsourced WIC services in these four HSRs to other WIC local agencies. There are now 67 local agencies.

Local agencies certify client eligibility, including assessing clients for health and nutritional risks; provide nutrition education and breastfeeding promotion; coordinate health care and referrals; issue food benefits; assist with authorization of grocery stores where clients redeem their food benefits; and conduct outreach for the program. Services are available in every county at approximately 550 clinics.

The DSHS WIC Policy and Procedures manual is available for review online at:
http://www.dshs.state.tx.us/wichd/policy/table_of_contents.shtm.
WIC has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/fchs.shtm.

**Nutrition, Physical Activity, and Obesity Prevention Program**

The DCP Services Division, Health Promotion and Chronic Disease Prevention Section administers the NPAOP Program. Central office staff and a statewide network of partnership agencies, organizations, and groups implement these programs and activities.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $524,461,635 |
| General Revenue | $0 |
| General Revenue-Dedicated | $206,840,000 |
| Other | $24,000,000 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**WIC - Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| NPAOP Program | NPAOP focuses on community-based interventions that promote policy and environmental changes in order to make healthy eating and physical activity easy choices. Both WIC and NPAOP are trying to improve the nutrition and increase the physical activity levels of Texans. | WIC is a clinically based program that focuses on nutrition education, referral to healthcare services, and the provision of healthy foods for a defined low-income population (pregnant and postpartum women, infants, and very young children). NPAOP works through community-based organizations that can influence all parts of the populations. NPAOP does not offer client-level education or clinical services. |

**WIC - External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Commodity Supplemental Food Program (CSFP) administered by TDA | CSFP also provides supplemental foods, has a common funding source (USDA), and provides services to low-income pregnant and postpartum women and children. | CSFP serves children up to age six, while WIC services end at age five. CSFP serves non-breastfeeding postpartum women up to one year, while WIC services end at six months postpartum, if the women is not breastfeeding. CSFP serves persons over age 60, while WIC serves women in their childbearing years. CSFP issues commodity foods, while WIC issues a smart card redeemable in over 2100 grocery stores statewide. CSFP caseload is |

| Name | Similarities | Differences |
|---|---|---|
| | | approximately 12,750, while the WIC caseload is over 900,000. CSFP operates in 12 counties only, while WIC operates statewide. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

According to 7 C.F.R., Parts 246 and 247, clients may not receive benefits from both WIC and CSFP administered by TDA. The two programs are required to enter into a written agreement to ensure the prevention, detection, and sanctioning of illegal dual participants. A memorandum of understanding is currently in effect between DSHS and TDA.

In 2008, DSHS identified obesity as a tier-one priority initiative to the agency. At that time, DSHS formed the Obesity Workgroup to collaborate across divisions to enhance DSHS efforts toward obesity prevention. The workgroup is comprised of representatives from DSHS WIC; the Office of Title V and Family Health, Research and Program Development Unit; and the DSHS NPAOP Program. Through cross-divisional collaboration, this group is able to leverage resources and avoid duplication of efforts, ultimately increasing internal capacity to prevent obesity across the agency.

Chapter 114, Texas Health and Safety Code, created the Interagency Obesity Council during the 80th Legislature, Regular Session, 2007, to address nutrition and obesity prevention among children and adults. The council comprises the commissioners of the DSHS, TDA, and the Texas Education Agency. The council serves to enhance communication and coordination of obesity prevention across agencies, and acts as a forum to guide future planning around obesity prevention, health promotion, and improved nutrition.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Special Supplemental Nutrition Program for Women, Infants, and Children - Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| LHDs, health and hospital districts, and city and county governments | These entities are WIC service providers. | These entities are DSHS sub-recipient contractors for WIC. |

**Special Supplemental Nutrition Program for Women, Infants, and Children - Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| USDA | USDA is responsible for administering WIC at the national and regional levels. | USDA provides oversight, guidance, and grant funding for WIC. |

**Nutrition, Physical Activity, and Obesity Prevention Program - Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| City of Austin Health Department | The City of Austin Health Department conducts pilots for restaurant portion control program (Tex-Plate) and Nutrition Environment Measures Assessment Tool. | DSHS partners with the City of Austin Health Department to address nutrition-related disparities in low socioeconomic neighborhoods. |
| City of Austin Health and Human Services | City of Austin Health and Human Services has one of the NPAOP-funded community projects. The project involves developing a community needs assessment to identify existing nutrition services and programs, and developing a plan to promote the availability of affordable healthy foods and beverages and supporting healthy food and beverage choices. | City of Austin Health and Human Services is a DSHS contractor funded through an Exceptional Item and Title V and selected through the competitive request for proposal (RFP) process. |
| City of Henderson | City of Henderson has a NPAOP-funded community project to establish a farmers' market with a permanent venue, prohibit advertising of unhealthy foods at all city parks, and provide meeting space at the farmers' market for conducting healthy food consumption seminars. | City of Henderson is a DSHS contractor funded through an Exceptional Item and Title V and selected through the competitive RFP process. |
| City of Houston Health and Human Services | The City of Houston Health and Human Services has a NPAOP-funded community project to establish farmers' markets in Neighborhood Wellness | The City of Houston Health and Human Services is a DSHS contractor funded through an Exceptional Item and Title V and selected through the competitive |

| Name | Description | Relationship to DSHS |
|---|---|---|
| | regions, food desert communities, and multi-service centers in various Houston communities. | RFP process. |
| City of San Antonio Metropolitan Health District | City of San Antonio Metropolitan Health District has a NPAOP-funded community project. Within a targeted area of Bexar county, the project implements nutrition standards and portions in city-sponsored afterschool sites and nutrition guidelines and portions in restaurants. The project also plans to implement at least one fruit and vegetable direct access/Farm to Work project. | City of San Antonio Metropolitan Health District is a DSHS contractor funded through an Exceptional Item and Title V and selected through the competitive RFP process. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts in this program for the following:

- nutrition services;
- interpreter services;
- translation services;
- media production services;
- audio visual presentation development;
- outreach and referral services in the colonias;
- launch of a collaborative quality improvement project with Texas hospitals to improve maternity care practices;
- nutrition, physical activity, and obesity prevention; and
- training of medical and public health professionals.

Amount of contracted expenditures in fiscal year 2012: $163,886,391
Number of program contracts: 822 (includes contract without expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $13,723,922 | City of Dallas | WIC services |
| $10,123,468 | Hidalgo County | WIC services |
| $9,818,354 | City of Houston | WIC services |
| $8,178,911 | Harris County | WIC services |
| $7,815,656 | North Texas Home Health Service, Inc. | WIC services |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

DSHS awards grants in this program for the following services:

- determining eligibility for WIC,
- providing food instruments,
- providing appropriate nutrition education and counseling,
- promoting and educating on benefits of breastfeeding,
- collecting financial, health, and nutritional data, and
- determining participants access to health care and make appropriate referrals.

Using sub-recipient contracts, the program awards grants in the following manner:

- through competitive solicitations, and
- on an emergency or sole source basis when an approved emergency or sole source justification waives competition.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

WIC is a nutrition services program intended to serve as an adjunct to good health care. The program operates on the premise that early food interventions during critical times of growth and development will improve the health status of participants and help prevent later health problems, thus saving costs for health care. In a 2006 rating of federal programs, the President's Office of Management and Budget (OMB) gave WIC an "effective" rating, the highest rating possible. Only 19 percent of federal programs received a rating of "effective." According to the White House report, "WIC has received the highest rating a program can achieve, because WIC has ambitious goals, achieves results, is well-managed, and improves program efficiencies." Evaluations provide strong evidence that WIC has a positive impact on the incidence of low birth weight and other key birth outcomes (which lead to savings in Medicaid costs), children's intake of key nutrients, and immunization rates. (Source http://www.whitehouse.gov/omb/expectmore/rating/effective.html)

The NPAOP Program focuses on community-based interventions that promote policy and environmental changes in order to make healthy eating and physical activity choices. Examples include increasing availability of fresh fruits and vegetables in inner city grocery stores, improving access to healthy foods at worksites, increasing neighborhood playgrounds where children can safely play and participate in more physical activity, promoting Safe Routes to schools, and making communities more walkable and bikeable.

Despite the fact that both the WIC and NPAOP programs are working to improve nutrition and increase the physical activity levels of Texans, each uses a different approach to achieve this common goal. WIC is a clinically based program that focuses on nutrition education with a specific target population; in contrast, NPAOP works through community-based organizations that can influence all parts of the population.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Community Capacity Building |
| **Location/Division** | 1701 North Congress - Family and Community Health Services (FCHS) Division |
| **Contact Name** | Evelyn Delgado, Assistant Commissioner, FCHS Division |
| **Actual Expenditures, FY 2012** | $7,951,880 |
| **Number of Actual FTEs as of June 1, 2013** | 6.5 |
| **Statutory Citation for Program** | Section 12.0127, Texas Health and Safety Code. Federal cooperative agreement cited in the U.S. Public Health Service Act, Section 42. |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

The Community Capacity Building Program has the following primary objectives.

- Develop and enhance capacities for community clinical service providers and regionalized emergency healthcare systems.
- Develop and support capacities for community healthcare services to qualified individuals.

Major activities include the following.

**County Indigent Health Care Program (CIHCP)**

CIHCP provides technical assistance to public hospitals, hospital districts, and county-run programs on indigent health care, administers state assistance funds for counties, resolves eligibility disputes, provides on-site quality assurance reviews, and files medical and prescription claims through the Texas Medicaid and Vendor Drug contractors for counties that have certified indigent residents who retroactively become eligible for Medicaid. The program also establishes and posts payment rates and standards for basic and optional healthcare services, as well as provides training and technical assistance to counties.

**Indigent Health Care Reimbursement Program**

The Indigent Health Care Reimbursement Program reimburses the provision of indigent health services through the deposit of funds in the state-owned multi-categorical teaching hospital account for the University of Texas Medical Branch (UTMB) at Galveston.

**Texas Primary Care Office (TPCO)**
TPCO uses federal funds to improve access to comprehensive primary medical care, dental, and mental health services. Activities include designating Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs). Providers and clinics may be eligible for incentives in designated areas that will improve access to health care. These programs include state- and federally- funded loan repayment programs for health professionals. TPCO also provides technical assistance in the development of nonprofit organizations and public entities to meet the federal requirements to become a federally qualified health clinic (FQHC) or FQHC Look-Alike (an organization that meets all of the eligibility requirements of a FQHC, but does not receive federal grant funding). TPCO also oversees the Texas Conrad 30 J-1 Visa Waiver Program, which allows foreign physicians to remain in the United States if they practice in MUAs for three years. National Health Service Corps (NHSC) provides loan repayment assistance to primary care medical, dental, and mental health clinicians who agree to practice in an HPSA. A Health Resources and Services Administration (HRSA) cooperative agreement funds TPCO activities for this program.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

The Community Capacity Building Program uses key statistics to determine the effectiveness and efficiency of the program.

**Texas Primary Care Office**
TPCO reports on four federal performance measures related to the number of obligated health professionals in underserved areas, expanding the number of approved sites for the NHSC, updating 551 HPSA designations, and providing technical assistance to communities and individuals to improve access to healthcare services.

**FQHC Incubator Program**
Initial federal grant awards for new FQHCs and the expansion of existing FQHCs total $37.2 million, with an Incubator investment of $25 million over five years. Federal funding becomes part of the FQHC's annual base grant funds. In 2011, the FQHC Incubator Program was defunded.

**J-1 Visa Waiver Program**
The J-1 Visa Waiver Program has recommended the maximum number of waivers each year since 2002. The total number of physicians placed in MUAs of the state is 311.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1990** – A court-ordered settlement, *Miram Pilson vs. Ronald Lindsey, et al.*, determines that the State is responsible for filing claims on behalf of counties for retroactive Medicaid Supplemental Security Income (SSI) payments.

**1999** – The Legislature authorizes the transfer of funds for the Indigent Health Care Reimbursement Program into the state-owned multi-categorical teaching hospital account. This program is expected to contribute to the statewide goal of promoting the health of the people of the State of Texas by improving quality and accessibility of healthcare services.

**2000** – HRSA implements the President's Initiative, a five-year plan to support new and expanding FQHCs throughout the United States. A key component of this initiative is to double the number of people served by FQHCs by awards for new access points, service expansion, and expanded medical capacity.

**2001** – House Bill 1018 allows DSHS to recommend up to 20 J-1 Visa Waivers per year, as authorized under the federal Conrad 20 Program, for physicians requesting an expedited license, and who intend to practice in an eligible area (the four counties served by the Valley Regional Academic Health Center), in a specialty required for accreditation, or employed as faculty.

**2003** – Senate Bill 610 establishes the FQHC Incubator Grant Program to support the expansion and development of FQHCs in Texas. House Bill 585 expands the Texas J-1 Visa Program to the entire state and increases the number of waivers DSHS may recommend from 20 to 30 per year. The Legislature also passes a rider stipulating that no county could receive more than 35 percent of the appropriated county indigent healthcare funds during the 2004-05 biennium. Additionally, the Legislature directs DSHS to distribute funds to eligible counties for at least 90 percent of the actual payments for healthcare services, after the county reaches the 8 percent expenditure level.

**2005** – Senate Bill 44 re-establishes the Indigent Health Care Advisory Committee until September 1, 2007. A rider also stipulates that no county could receive more than 20 percent of the appropriated county indigent healthcare funds in the 2006-07 biennium.

**2007** – The Legislature limits the amount of state assistance any one county may receive through county indigent healthcare funds to no more than 10 percent of the total state assistance funds. The Legislature also adds special restrictions related to indigent patients from Galveston, Brazoria, Harris, Montgomery, Fort Bend, and Jefferson counties receiving care from the UTMB teaching hospital.

**2009** – The Legislature permits distribution of county indigent healthcare funds exceeding the 10 percent allocation limit, if there are no counties below the limit eligible for additional funding. House Bill 2154 changes the tax rate for smokeless tobacco to support and expand the Physician Education Loan Repayment Program.

**2012 –** The Legislature provides no new funds for the FQHC Incubator Program, although some contracts continue through August 31, 2012. TPCO continues to provide technical assistance to FQHCs, Look-Alikes, and organizations interested in becoming an FQHC.

**2013** – The Legislature passes provisions to allow counties to credit Intergovernmental Transfers (IGTs) toward up to four percent of their eligibility for state assistance through CIHCP if the county commissioner's court determines that the IGT was expended on eligible residents for eligible services.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

**County Indigent Health Care Program**
Counties not covered by a public hospital or hospital district that provide health care to county residents whose income level is at or below 21 percent federal poverty level (FPL) and who are not eligible for Medicaid programs can request reimbursement for some of these costs from the state assistance funds. There are 143 county-run programs, 136 hospital districts, and 19 public hospitals that locally administer the program. Of the county-run programs, an average of about 10 counties request and receive state assistance funds each fiscal year. In fiscal year 2012, eight counties received state assistance funds for providing services to 1,583 clients.

**Indigent Health Care Reimbursement Program**
In fiscal year 2012, the Indigent Health Care Reimbursement program provided $5,750,000 to UTMB at Galveston for unpaid healthcare services provided to indigent patients.

**FQHC Incubator Program**
The FQHC target population is persons whose income is below 200 percent FPL and who are residing in an MUA. An FQHC is required to provide primary and preventive care, dental, behavioral health, and substance abuse services across the life span regardless of a person's ability to pay for services. For those patients who receive Medicaid and Medicare benefits, the federal government reimburses an FQHC (and FQHC-Look Alike) based on actual operating costs. The FQHC Incubator Program supports FQHCs to expand services or become federally grant-funded to serve the underserved population. Although the Legislature did not fund the program in 2011, the program's statutory language remains in place, should funding become available in the future.

**J-1 Visa Waiver Program**
There are 87 physicians currently fulfilling three-year service obligations, practicing in 25 federally- designated MUAs or HPSAs.

**Recruitment and Retention Assistance**

The combined loan repayment programs benefit medically underserved people in Texas by incentivizing qualified healthcare professionals to provide health care in critical shortage areas. The total number of health professionals that can enroll in the state-funded programs each year is 100, with each serving a four-year obligation. In 2011, due to a funding loss, DSHS eliminated some of the loan repayment program, and the Texas Higher Education Coordinating Board began administering the program. Although the TPCO no longer administers this program, it serves as the liaison for HRSA and provides technical assistance to the program.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The FCHS Division administers all Community Capacity Building activities, except the Indigent Health Care Reimbursement Program, which the Chief Financial Officer (CFO) administers.

**Indigent Health Care Reimbursement Program**

Central office staff in the CFO Office provides technical assistance and processes monthly reimbursement claims for this program. DSHS may use Indigent Health Care funds to reimburse UTMB for providing healthcare services to indigent patients from all counties, except indigent patients from Galveston, Brazoria, Harris, Montgomery, Fort Bend, and Jefferson counties. In these counties, DSHS may only use the funds if the eligibility levels of those counties' County Indigent Health Care Program or hospital district income exceed the statutory minimum set for CIHCP.

**County Indigent Health Care Program**

The FCHS Division, Community Health Services Section, Primary and Preventive Care Unit administers CIHCP. Program and contract support staff is located at DSHS central office in Austin. Central office CIHCP staff provides technical assistance and training, audits Medicaid Supplemental Security Income (SSI) claims, processes reimbursement requests to counties, files medical claims on behalf of counties, and reviews monthly expenditure reports for county-run programs. In addition, the program provides matching funds to eligible counties who expend greater than eight percent of their tax levy on qualified medical services to eligible county residents. The CIHCP policy/procedure manual is available for review at: http://www.dshs.state.tx.us/cihcp/.

**Texas Primary Care Office**

TPCO administers federal funds for healthcare shortage designations through a cooperative agreement with the HRSA and the Conrad 30 J-1 Visa waiver Program. Program and support staff is located at the DSHS central office in Austin.

**J-1 Visa Waiver Program**

The J-1 Visa Waiver Program receives applications from physicians in September each year. The program makes visa recommendations to the U.S. Department of State in accordance with federal legislation. TPCO monitors the J-1 Visa Program through site visits and phone calls to physicians and employers. The J-1 Visa Waiver website is:
http://www.dshs.state.tx.us/chpr/j1info.shtm.

**Recruitment and Retention Assistance**

The federally and state-funded loan repayment programs assist health professionals, clinics, hospitals, and healthcare providers to improve access to healthcare services. Texas Higher Education Coordinating Board administers the state-funded loan repayment programs. TPCO provides technical assistance and information regarding federal and state loan repayment programs for both providers and potential healthcare organizations that may be an appropriate placement. The TPCO, Recruitment and Retention website is:
http://www.dshs.state.tx.us/chpr/TPCO_INFO.shtm and www.txlrp.org.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/fchs.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $120,578 |
| General Revenue | $581,302 |
| General Revenue-Dedicated | $5,750,000 |
| Other | $1,500,000 |

State legislation authorizes funding the Texas Conrad 30 J-1 Visa Waiver Program to collect application fees for support of the program. Application fees net $76,000 per year.

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

No internal or external programs provide similar services or functions.

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers.**

**If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

CIHCP staff provides training to county and hospital staff regarding the differences between Medicaid and CIHCP eligibility requirements.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**County Indigent Health Care Program - Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Local health departments (LHDs) | LHDs administer the indigent healthcare program, provide referrals for indigent care services, and/or provide indigent care services. | CIHCP provides technical assistance on eligibility and payment standards by statute. |
| Hospital districts | Hospital districts have a statutory obligation to administer the indigent care program in their service areas and to provide indigent care services. | CIHCP provides technical assistance on eligibility and payment standards by statute. |
| Local county officials | Local county officials (such as judges, auditors, and treasurers) oversee the administration of the county indigent healthcare program. | DSHS provides technical assistance on eligibility and payment standards by statute. Counties exceeding eight percent General Revenue tax spending receive state assistance funds. |

**FQHC Incubator Program - Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| LHDs, hospital districts, and health districts | These entities seek the guidance of TPCO in converting clinics to FQHC status. | LHDs and other public entities may be eligible to become FQHCs, but may need assistance with meeting the federal program requirements. For example, dental and behavioral health services are FQHC requirements not usually offered by LHDs, public hospitals, or hospitals districts. |

**FQHC Incubator Program - Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| HRSA, Bureau of Health Professions, Bureau of Clinician Recruitment Services (BCRS) and Bureau of Primary Health Care | The HRSA bureaus support state level infrastructure building activities to measure and improve access to primary healthcare services. | Through a cooperative agreement with TPCO, each of the HRSA bureaus support improving access through measurement of underserved and provider shortage areas, resources to recruit and retain health professionals who serve the underserved, and funding for FQHCs. Funding to DSHS supports these activities while HRSA directly funds participants and organizations that employ providers and serve as safety net sites. |

**J-1 Visa Waiver Program - Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| U.S. Department of State (DOS) and U.S. Department of Homeland Security (DHS) | DOS receives J-1 Visa Waiver applications to review and recommends the waiver to DHS. | TPCO makes a request though the DOS to recommend an H-1B visa to the DHS, which allows employers to employ temporarily foreign workers in specialty occupations. |

**Recruitment and Retention Assistance - Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| HRSA, BCRS, NHSC | HRSA BCRS administers the NHSC Scholarship and Loan Repayment Programs as national initiatives to increase access to healthcare professionals. | TPCO receives grant funding from HRSA for this program. TPCO markets the NHSC program, facilitates the site and provider applications, and serves as the state liaison to the program. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

TPCO has no contracted expenditures due to a discontinuation of the FQHC Incubator Program. CIHCP does not operate on a contractual basis. The Indigent Health Care Reimbursement Program provided $5,750,000 to UTMB Galveston for unpaid healthcare services provided to indigent patients in fiscal year 2012.

**L. Provide information on any grants awarded by the program.**

The program does not award grants.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory change to assist the program in performing its functions.

**Chapter 61, Texas Health and Safety Code** – The program recommends adding compliance or enforcement language to this statute for reporting the provision of indigent health care in Texas. Currently, there is no reporting requirement, so the data are incomplete.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

**Regulatory Services Division (RSD)**
Kathy Perkins, Assistant Commissioner

**FTEs: 755.5**

The RSD provides oversight, monitoring, and strategic direction for implementing programs to regulate emergency medical services (EMS), trauma services, food and drug safety, environmental health, radiation use, healthcare professionals, and healthcare facilities. RSD has included detailed information about regulatory services provided to each of these licensing categories in a separate Section VII description.

Organizationally, the division has two sections and one unit reporting to the Assistant Commissioner.

- Health Care Quality Section establishes and administers rules and standards to maintain the health and safety of Texans by performing licensing, surveying, and inspection activities for healthcare providers, allied health professionals, and related programs and services.
- Environmental and Consumer Safety Section establishes regulatory standards and policies consistent with federal requirements and conducts compliance activities to protect public health related to foods (including meat), drugs, uses of radiation, and environmental hazards.
- The Enforcement Unit ensures compliance with all DSHS regulations and processes enforcement cases.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Strategy** | Emergency Medical Services (EMS) and Trauma |
| **Location/Division** | 8407 Wall Street, Austin - Regulatory Services Division (RSD) |
| **Contact Name** | Kathryn C. Perkins, Assistant Commissioner, RSD |
| **Actual Expenditures, FY 2012** | $68,903,514 |
| **Number of Actual FTEs as of June 1, 2013** | 20.9 |
| **Statutory Citation for Program** | Chapter 773, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

EMS and Trauma has as its primary objective to develop and enhance regionalized emergency healthcare systems. Major activities include the following.

**Trauma Facility Designation**
Trauma Facility Designation ensures that the citizens and visitors of Texas receive quality trauma-care services provided by qualified designated trauma facilities that meet essential criteria. Staff conducts site surveys and/or reviews site survey reports of approximately 80 hospitals annually and monitors compliance with Trauma Facility Designation rules that require expeditious, appropriate, quality care for major and severe trauma patients.

**Stroke Facility Designation**
Stroke Facility Designation ensures that the citizens and visitors of Texas receive quality stroke-care services provided by qualified designated stroke facilities that meet essential criteria. Staff conducts site surveys and/or reviews site survey reports of approximately 50 hospitals annually; and monitors compliance with stroke facility designation rules that require expeditious, appropriate, quality care for stroke patients.

**Regional EMS/Trauma Systems Designation**
Regional EMS/Trauma Systems Designation encourages the growth of regional EMS/trauma systems by providing technical assistance to each Regional Advisory Council (RAC) to develop DSHS-approved regional trauma plans. The plans include the following components: injury prevention, access to the regional system, communications, medical oversight, pre-hospital triage criteria, diversion policies, bypass protocols, regional medical control, inter-hospital transfers, planning for designation of trauma facilities, and a system process improvement program. Regional EMS/Trauma Systems Designation facilitates and encourages RACs to

establish and monitor public health trends in traumatic death or disability, address community-injury health problems through prevention education, and implement system process improvement activities based upon data collection and monitoring.

**EMS/Trauma Systems Grants**

EMS/Trauma Systems Grants staff manages funding programs to assure that emergency first responders and EMS providers are available around the state to provide emergency care and transport. Additionally, funding programs assure that RACs build local regional trauma care systems that deliver major and severe trauma patients to the appropriate trauma facilities. Funding programs provide for the reimbursement of a portion of the uncompensated trauma care provided by eligible hospitals. The grants fund equipment and staff educational programs, as well as provide emergency grant monies for extraordinary situations when there is a potentially serious degradation of EMS services to a community. The grants also help fund communication and medical equipment needed to facilitate access to the regional EMS/trauma system. Whenever possible, staff determines awards through funding based on local need.

**Stakeholder Information**

Stakeholder Information provides technical assistance and education to the public about "Out of Hospital-Do Not Resuscitate" processes. Through injury prevention materials and media releases, staff educates the public about the role of EMS and the ways in which EMS can save lives. Staff also provides continuing education through the Texas EMS Conference, which draws more than 3,000 attendees from around the state, to ensure that medical continuing education courses for EMS personnel and emergency/trauma nurses are available at an affordable price. Each issue of *Texas EMS Magazine* contains a continuing education article and stakeholders have access to information through the website at:
http://www.dshs.state.tx.us/emstraumasystems/default.shtm.

RACs and over 54,000 EMS personnel in Texas also have access to articles in *Texas EMS Magazine* and press releases that assist them in teaching injury prevention techniques and strategies in communities across the state.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

EMS and Trauma measures the effectiveness and efficiency of its functions by the ongoing monitoring and continued development of designated trauma and stroke facilities. In fiscal year 2012, DSHS provided EMS/Trauma Systems funding to 2,523 providers.

| | Texas Regional EMS/Trauma Systems | Texas Designated Trauma Facilities | Texas Designated Stroke Facilities | Texas Trauma Mortality Rates per 100,000 |
|---|---|---|---|---|
| **1989** | | 0* | | 60.00* |
| **1998** | | 108** | | |
| **2000** | | 183** | | 52.61**** |
| **2006** | 22*** | 242*** | | 56.50**** |
| **2008** | 22*** | 244*** | | 55.18**** |
| **2009** | 22*** | 246*** | | 56.08**** |
| **2010** | 22*** | 256*** | 57 Level II Primary Stroke Facilities* | 54.63**** |
| **2011** | 22*** | 262*** | 83 Level II; 1 Level III | |
| **2012** | 22*** | 276*** | 94 Level II; 3 Level III | |
| **2013** | 22*** | 268***** | 2 Level I; Level II 108; 4 Level III | |

* *Texas Trauma System: Interim Report on the EMS/Trauma System Fund*, September 1998. Texas Department of Health (TDH), Bureau of Emergency Management.

** *EMS and Trauma Care Systems Account: Final Report to the 77th Legislature*, February 2001. TDH, Bureau of Emergency Management.

*** DSHS Office of EMS/Trauma Systems.

**** *Centers for Disease Control WISQARS Injury Mortality Report*, age adjusted 2000 standard year (last statistics available in 2010).

***** The decrease in the number of facilities with trauma designations from 2012 to 2013 is due to 13 facilities that underwent a change of ownership, which rendered them undesignated in 2013. These same facilities immediately re-entered the program "in active pursuit of designation," meaning the facility is required to acquire trauma facility designation within two years from the date of entering such status.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1989** – The Omnibus Rural Health Care Rescue Act directs the Bureau of Emergency Management of TDH to develop and implement a statewide EMS and Trauma Care System, designate trauma facilities, create the Trauma Technical Advisory Committee, and develop a trauma registry to monitor the system and provide statewide cost and epidemiological statistics. The act does not provide funding for the endeavor at that time; however, in 1997, the Legislature establishes funding for this activity.

**1992** – The Texas Board of Health adopts rules for implementation of the trauma system. These rules divide the state into 22 regions called trauma service areas (TSAs), provide for the formation of a RAC in each region to develop and implement a regional trauma system plan,

delineate the trauma facility designation process, and provide the development of a state trauma registry.

**1995** – All TSAs establish RACs and all RACs have regional system plans approved by TDH, now DSHS. The Texas EMS/Trauma System continues to develop RACs and implement regional EMS/trauma systems, active quality performance improvement programs, and effective intra-regional communication systems that allow almost immediate contact with their membership. Many expand their roles to include other projects, such as participation in hospital, disaster, and bioterrorism preparedness planning and development of acute care coordination in the form of stroke and cardiac care protocols.

**1998** – The Board of Health adopts rules to require EMS and hospital participation in the development of regional trauma systems and regional system plans, and submission of data to the state registry. TDH disburses funds to EMS providers and RACs to promote system development and to hospitals for uncompensated hospital trauma care.

**2003** – The Legislature adds Section 12.0111, Texas Health and Safety Code, which requires DSHS to charge a fee sufficient to cover the cost of administering and enforcing the stroke designation program.

**2005** – Senate Bill 330 amends Sections 773.204 and 773.205, Texas Health and Safety Code, and requires DSHS, with the assistance of the Governor's EMS and Trauma Advisory Council and its Stroke Committee, and in collaboration with the Texas Council on Cardiovascular Disease and Stroke, to develop stroke facility criteria and a statewide stroke emergency transport plan.

**2013** – House Bill 15 amends Chapter 241, Texas Health and Safety Code. The new Subchapter H requires HHSC and DSHS, with the assistance of a newly created Perinatal Advisory Council, to develop and implement a statewide Perinatal and Maternal Care System, to divide the state into neonatal/maternal care regions, and to designate neonatal and maternal levels of care facilities.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

The EMS and Trauma System affects all citizens and visitors to Texas. Approximately 39 Texans die every day from injuries, at a rate of almost 13,750 a year. Since trauma is the leading cause of death in persons ages 1-44, the years of potential life lost are staggering – approximately 347,000 in 2010. Using a per-capita income of $25,548, this represents $8.86 billion in lifetime income lost and a reduction to the state in lifetime tax revenues of $1.07 billion for that one year of trauma mortality alone.

Every 45 seconds, someone in America has a stroke. About 700,000 Americans will have a stroke this year. Stroke is the nation's number three killer and a leading cause of severe, long-term disability.

House Bill 15, 83rd Legislature, Regular Session, 2013, directs DSHS to designate neonatal and maternal levels of care. In order to receive Medicaid reimbursement, DSHS must designate a facility separately as either maternal or neonatal services. DSHS anticipates that the 253 facilities currently providing these services will seek designation for either or both services. If all 253 receive designation, this will exceed the number of facilities currently in the trauma and stroke designation programs combined.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

RSD, Office of EMS/Trauma Systems Coordination administers EMS and Trauma. Sections 773.119 and 773.122, Texas Health and Safety Code, charge the Office of EMS/Trauma Systems with establishing a program to award grants that initiate, expand, maintain, and improve EMS and to support medical systems and facilities that provide trauma care. The program staff manages the distribution of the EMS/Trauma Care System Account; EMS, Trauma Facilities, and Trauma Care System Fund; Permanent Fund for EMS and Trauma Care (Tobacco Endowment Fund); and the Designated Trauma Facility and EMS Account. Funding programs include local project grants to EMS providers, first responder organizations, EMS education organizations, and pre-hospital injury prevention organizations; RAC development grants; extraordinary emergency fund grants to EMS providers, first responder organizations, and trauma facilities; emergency care attendant training grants to EMS providers and first responder organizations; and uncompensated trauma care grants to EMS providers, RACs, and trauma facilities.

Section 773.113, Texas Health and Safety Code, charges the Office of EMS/Trauma Systems with developing and maintaining statewide EMS and trauma care systems, and a method for trauma reporting and analysis system. Section 773.115, Texas Health and Safety Code, mandates designating trauma facilities that are part of an EMS trauma care system at four levels:

- Level I: comprehensive trauma facility,
- Level II: major trauma facility,
- Level III: advanced trauma facility, and
- Level IV: basic trauma facility.

DSHS designates Level I and Level II trauma facilities in accordance with American College of Surgeons (ACS) guidelines and additional rules adopted by DSHS. DSHS designates Level III trauma facilities in accordance with rules adopted by DSHS and ACS guidelines or those of another DSHS-approved organization. DSHS designates Level IV trauma facilities in accordance with rules adopted by DSHS. To ensure concordance, DSHS staff secondarily reviews

conclusions about a hospital's trauma-care performance standards documented by the ACS surveyors in their trauma facility site survey reports. Facilities that contract directly with ACS bear the survey costs.

The Office of EMS/Trauma Systems also assists in the development of stroke facility criteria and a statewide stroke emergency transport plan, in accordance with Sections 773.204 and 773.205, Texas Health and Safety Code. DSHS designates stroke facilities that are part of the regionalized emergency healthcare systems at three levels:

- Level I: comprehensive stroke facility,
- Level II: primary stroke facility, and
- Level III: support stroke facility.

DSHS designates Level I and Level II stroke facilities in accordance with The Joint Commission (TJC) Comprehensive Stroke and Primary Stroke Certification Program. DSHS designates Level III stroke facilities in accordance with DSHS support stroke criteria, the DSHS-approved survey organization for trauma and stroke, and additional DSHS rules. To ensure concordance, DSHS staff secondarily reviews conclusions about a hospital's stroke-care performance standards documented by TJC surveyors' site survey reports. Facilities that contract directly with TJC bear the survey costs.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/regulatory.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $0 |
| General Revenue | $22,963 |
| General Revenue-Dedicated | $68,880,551 |
| Other | $0 |

There are no funding appropriations for stroke facilities and neonatal maternal facilities at this time.

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| DSHS Healthcare Facility Licensing | DSHS uses patient-centered rules establishing minimum standards for general hospital licensing procedures, and trauma-facility designation essential criteria. The rules include such things as fees, operational requirements, inspection and investigation procedures, license/designation denial, suspension, and revocation. | Hospitals operating in Texas most follow DSHS rules establishing minimum standards. DSHS allows voluntary adherence to rules for establishing minimum trauma facility designation standards, although significant funding opportunities associated with adherence exist. |

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| ACS Trauma Verification Program | ACS verifies a hospital's trauma care capability and performance by an on-site review of the hospital to evaluate compliance with ACS Level I and II essential criteria. The review team consists of experienced trauma surgeons, an emergency physician, and trauma nurses. | DSHS designation is a formal recognition of a hospital's trauma care capabilities and commitment verified by ACS for Level I and II designation or by an on-site review to evaluate compliance with DSHS Level III and IV essential criteria. The review team consists of experienced trauma surgeons and nurses. |
| TJC | Through an on-site survey review process, TJC verifies compliance with TJC standards and issues findings in the form of facility accreditation of certification for disease specific programs. TJC provides stroke center certification that indicates a hospital meets TJC performance standards. | TJC accreditation and stroke certification is a nationwide seal of approval for all hospital departments. DSHS designation is a state-specific process that recognizes the performance standards of those areas of the hospital that affect stroke patients. Designation also indicates that the facility participates in the regional stroke system of its TSA. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

A Level I or Level II DSHS-designated trauma facility must meet, among other things, the current ACS essential criteria for verification, as required by Title 25, Texas Administrative Code, Section 157.125, Requirements for Trauma Facility Designation. While there are no memorandums of understanding, ACS staff performs and documents hospital survey reports which, by rule, serve as an acceptable part of the trauma facility designation process. Additionally EMS and Trauma Program staff consults the ACS Committee on Trauma's *Resources for Optimal Care of the Injured Patient* during trauma facility designation rules reviews in order to ensure that state standards are similar to national standards of trauma care.

Level I or II DSHS-designated stroke facilities must meet, among other things, TJC essential criteria for certification, as required by Title 25, Texas Administrative Code, Section 157.133, Requirements for Stroke Facility Designation. While there are no memorandums of understanding with TJC, TJC staff performs and documents hospital survey reports which, by rule, serve as an acceptable part of the stroke facility designation process. Additionally, during rule review and to ensure standards are similar to national standards, DSHS relies on recommendations from the Stroke Committee of the Governor's EMS and Trauma Advisory Council, in collaboration with the Texas Council on Cardiovascular Disease and Stroke, which refers to the Brain Attack Coalition's essential criteria for Level I and II stroke centers.

Neonatal and maternal levels of care designations have not been developed in rule; however, DSHS is not aware of any national, regional, or state organization that is currently providing accreditation, verification, or certification at any level for either neonatal or maternal levels of care.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Hospital districts | Hospital districts provide medical assistance, including hospitalization when required, to indigent persons residing within their geographic boundaries. | No direct relationship exists; however, DSHS has designated as trauma facilities many hospitals funded by hospital districts as safety net hospitals for indigent persons. |
| Academic health science centers | Academic health science centers train health professionals, conduct research that advances health, and provide care especially to the most ill and poorest populations. | No direct relationship exists; however, DSHS has designated as trauma facilities most academic health science centers that serve as safety net hospitals for indigent persons. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts in this program for the following:

- EMS attendance certification training;
- emergency funding for hospitals and EMS providers with disruption of services;
- equipment, supplies, and operational expenses for EMS providers;
- trauma systems development for EMS providers and RACs;
- ambulances during disasters;
- partnership to train nurses and physicians in emergency and trauma care;
- funding to create a Medicaid "Trauma Add-on" to maximize funding to hospitals for uncompensated trauma care; and
- disbursement to hospitals for a portion of uncompensated trauma care.

Amount of contracted expenditures in fiscal year 2012: $8,479,490
Number of program contracts: 446 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $310,983 | North Central Texas Trauma RAC | Trauma systems development for EMS |
| $292,418 | Southwest Texas RAC | Trauma systems development for EMS |
| $286,387 | North Texas Central Trauma RAC | Trauma systems development for RACs |
| $286,057 | Texas J RAC | Trauma systems development for EMS |
| $261,359 | Southeast Texas RAC | Trauma systems development for EMS |

Regional emergency medical services and trauma systems funding is tied to performance, which is measured by contractual benchmarks. Each of the 22 RACs operates as a 501(c)(3) nonprofit organization. DSHS staff monitors performance through quarterly and annual financial and programmatic reporting. Biannually, each RAC completes a self-assessment followed by programmatic desk audit.

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

DSHS awards local project grants in this program for EMS. In fiscal year 2012, DSHS made 108 awards ($1,171,935) for EMS-related equipment, supplies, education, training, and emergency response vehicles for EMS providers, first responders, and EMS education providers. The program awards grants through competitive solicitations.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS – CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Strategy** | Food and Drug Safety |
| **Location/Division** | 8407 Wall Street, Austin - Regulatory Services Division (RSD) |
| **Contact Name** | Kathryn C. Perkins, Assistant Commissioner, RSD |
| **Actual Expenditures, FY 2012** | $23,396,766 |
| **Number of Actual FTEs as of June 1, 2013** | 335.5 |
| **Statutory Citation for Program** | Chapters 145, 146, 431, 432, and 486, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

The primary objective of Food and Drug Safety is to design and implement regulatory programs to ensure the safety of food, drugs, and medical devices. Major activities include the following.

**Foods Manufacturing Program**
The Foods Manufacturing Program inspects food processors, wholesalers, certificates of free sale, warehouse operators, and food salvage establishments; establishes standards and ensures compliance through voluntary means and formal enforcement; and tests and issues certificates of competency to operators of bottled and vended water establishments.

**Foods Establishment Program**
The Foods Establishment Program inspects retail food establishments in Texas that local jurisdictions do not inspect; establishes standards and ensures compliance through voluntary means and formal enforcement; and tests and issues certifications for the certified food manager and food service worker programs. The Foods Establishment Program also accredits food handler education or training programs, conducts school cafeteria inspections, and trains local inspectors.

**Drugs and Medical Devices Program**
The Drugs and Medical Devices Program inspects drug and medical device manufacturers and wholesale distributors, such as tattoo, tanning, and body piercing facilities, and retailers of pseudo-ephedrine containing products. The group establishes standards and ensures compliance through voluntary means and formal enforcement procedures.

**Meat Safety Assurance (MSA) Program**
The MSA Program ensures that retailers produce goods bearing the *Texas Mark of Inspection* come from healthy livestock animals that are humanely slaughtered and are prepared in a sanitary manner, contain no harmful ingredients, and are truthfully labeled. The MSA Program conducts inspections of 100 percent of livestock animals presented for humane slaughter and performs daily inspections of livestock slaughter and meat and poultry processing facilities engaged in intrastate sales. The program establishes standards and ensures compliance by both voluntary means and formal enforcement procedures to maintain the meat inspection program "at least equal to" the U.S. Department of Agriculture (USDA) federal standards in accordance with state law.

**Milk and Dairy Products Program**
The Milk and Dairy Products Program inspects milk processing plants, cheese manufacturers, dairy farms, manufacturers of frozen desserts, and milk transportation operations. The Milk and Dairy Products Program establishes standards and ensures compliance by both voluntary means and formal enforcement procedures.

**Seafood Program**
The Seafood Program inspects molluscan shellfish and crabmeat harvesters and processors and monitors fish from public waterways and shellfish growing and harvesting areas for chemical and microbiological contaminants. The Seafood Program establishes standards and ensures compliance through voluntary means and formal enforcement.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

The functional alignment of activities as described in Question E streamlined the process of Food and Drug Safety inspections, eliminated overlap, and provided for more uniformity by using common resources including personnel and equipment. In addition, functional reorganization has enabled RSD to establish uniform policies and procedures and unified enforcement activities. Reorganization has aided the program in completing many of the previous Sunset Commission Review recommendations noted below.

Following the passage of House Bill 2085, 76th Legislature, Regular Session, 1999, as a follow-up to Sunset Commission Review of the agency, DSHS regulatory programs implemented numerous changes to improve effectiveness and efficiency. These changes include a wide array of topics, including the following:

- cross-utilization of staff when appropriate;
- standard processes for review of completed inspection reports to ensure uniformity;
- direct line authority by the Austin office over the field staff in most programs;
- implementation of Enforcement Review Committees for formal enforcement for all programs;

- standardized enforcement policy;
- additional enforcement authorities for several programs (amendments to laws);
- institution of an "informal settlement" procedure;
- publication of final enforcement actions and trends;
- expanded programmatic and licensing information on program websites;
- participation in the Texas e-Government portal for licensing; and
- solicitation of more stakeholder input into the rulemaking process.

During fiscal year 2012, regulatory programs obtained thousands of documented voluntary corrections of unsanitary conditions during inspections of regulated industries, thereby averting numerous potential illnesses, injuries, and/or deaths from conditions that might have adulterated and/or contaminated foods, drugs, and medical devices destined for public distribution. Food and Drug Safety staff calculates the cost of correcting these conditions as $7 million.

During fiscal year 2012, Food and Drug Safety Program staff witnessed the voluntary destruction of the following foods, drugs, and medical devices found to be adulterated, contaminated, or misbranded:

- 32,618 pounds of meat in retail stores valued at $113,510;
- 427 units of drugs and devices valued at $3,165;
- 94,883 pounds of meat at meat plants valued at $475,000, not including the pounds of product condemned voluntarily by establishments; and
- 4,543,401 pounds of milk valued at $734,213.

These were products intended for sale to consumers in Texas and elsewhere. By discovering and removing these products, Food and Drug Safety prevented public exposure to these items and the threats to public health and safety.

Federal agencies conduct formal audits of certain areas within Food and Drug Safety to ensure that they are operating in a manner consistent with federal counterparts as far as grants, contracts, and funding. These areas are the Medical Devices, U.S. Food and Drug Administration (FDA) contract inspection program; the Manufactured Foods, FDA contract inspection program; the Foods Country of Origin Labeling, USDA contract inspection program; and the Meat Safety, USDA inspection program. For example, the MSA Unit, which is 50 percent funded by USDA, receives significant attention from USDA's Food Safety and Inspection Service (FSIS) similar to the other 26 states that have state meat-inspection programs. The MSA Unit must maintain its "equal to" status to receive federal funding. To meet the USDA federal requirements, the MSA Unit must inspect 100 percent of livestock animals presented for humane slaughter and must conduct daily inspections at meat and poultry processing establishments that wholesale their products for intrastate commerce. The MSA Unit submits yearly self-assessments to USDA/FSIS, and USDA/FSIS conducted on-site evaluations of the Meat Safety Program in 2006, 2009, and 2012. The MSA Unit has continually met all federal standards and requirements.

Food and Drug Safety has procedures to ensure that inspectors maintain a required number of inspections. The Manufactured Foods FDA contract inspection program requires state inspectors to pass yearly inspection audits conducted by FDA personnel. Additionally, Food and Drug Safety conducts audit desk reviews of completed reports to ensure the laws and rules are properly enforced, the reporting of violations, and the completeness and thoroughness of reports and evidence to document violations. The staff receives explicit training in these areas.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1990s** – Food and Drug Safety implements a risk assessment to ensure that the program uses limited resources are for the greatest impact on public health. Each area evaluates the risks posed by the regulated products and establishments, so that the products and facilities presenting the greatest risk to public health receive the greatest attention.

**2001** – The legislatively mandated Business Practices Evaluation Report finds that the legacy Texas Department of Health (TDH) needs a complete reordering of the administrative and organizational infrastructure in order to function efficiently. In response to findings, Food and Drug Safety undergoes staff reorganizations that centralize inspection teams within programs and combine certain programs according to functionality.

**2003** – Senate Bill 1152 requires Food and Drug Safety to provide regulated entities the option of renewing licenses via Texas Online, the official e-government website. The Legislature also mandates two-year terms for each license issued by state agencies. This requirement applies to licenses, permits, registrations, and certificates issued or renewed on or after January 1, 2005, and to all activities within Food and Drug Safety, except meat safety grants of inspection that do not expire.

As a result of legislation that passes in 2003, Food and Drug Safety realigns into functional units. TDH combines policies, standards, and quality assurance for all programs, as well as all inspection activities, licensing, and enforcement. Prior to this reorganization, Food and Drug Safety had seven separate divisions, with each division operating each aspect (policies, procedures and standards; compliance; and enforcement) independently, with the exception of licensing that DSHS combined at the bureau level. The reorganization also leads to locating all central office Food and Drug Safety staff within a single building, which improves communications and leads to improved efficiency in operations.

**2005** – The RSD enters into a contract for the creation of a Regulatory Automation System (RAS). RAS integrates licensing, inspection, investigation, enforcement, and compliance activities. This combined database eliminates the need and cost to maintain separate systems for licensure, inspections, and other database documentation.

**2006** – DSHS amends rules concerning the regulation of retail food establishments to reflect current science and knowledge regarding best practices, emerging pathogens, and new retail food technologies. The new rules are consistent with the current FDA model Food Code.

**2007** – Senate Bill 943 establishes inspection requirements and exemptions under the Prescription Drug Monitoring Act, federal law and regulations regarding state licensing of wholesale drug distributors and accompanying operation requirements.

**2009** – Senate Bill 1645 establishes additional pedigree exemptions for secondary wholesale drug distributors, which are firms that receive their drugs from other wholesale drug distributors. The Legislature requires these firms to pass pedigrees, a paper trail from the sale of the drug from the manufacturer through all subsequent sales. This bill exempts government-run, nonprofit wholesalers that provide drugs to mental health hospitals from the pedigree requirement.

**2009** – Senate Bill 1271 amends Chapter 605, Texas Occupations Code, to require licensure for an orthotist or a prosthetist as a device manufacturer, if fabricating or assembling without an order from certain healthcare professionals.

**2009** – House Bill 1310 requires DSHS to initiate rulemaking efforts to conduct inspections where appropriate to ensure compliance with the new provisions for tanning salons.

**2009** – Food and Drug Safety elects to participate in a grant program to develop a rapid response team (RRT). The scope of the RRT is to provide preparedness, prevention, and an immediate response to a food/feed-related disaster affecting the citizens of Texas. This includes a large-scale investigation involving food and/or feed and large scale recalls of food and/or feed. The intended scope of the RRT does not include natural disasters (e.g., hurricanes or forest fires); however, there are outcomes from natural disasters that are within the scope of the RRT, such as flooding, windstorms, tornadoes, power outages, and fires, if the food chain is threatened and the outbreak is not part of a statewide emergency response activation.

**2010** – Food and Drug Safety includes the Manufactured Food Regulatory Program Standards as part of a contract with the FDA for conducting inspections of food manufacturers. The program standards establish a uniform foundation for the design and management of state programs responsible for the regulation of food plants. Additionally, the program standards establish requirements for staff training, inspection, quality assurance, food defense preparedness and response, foodborne illness and incident investigation, enforcement, education and outreach, resource management, laboratory resources, and program assessment.

**2010** – House Bill 2729 requires DSHS to develop rules to allow donation of unused, unopened, non-dispensed medications. The rules limit donations to pharmacies, physicians, wholesalers, and manufacturers that want to donate drugs that are in stock and not dispensed to patients.

**2011** – The Legislature adds requirements for cottage food production operations to Chapter 437, Texas Health and Safety Code. DSHS adopts rules to require a cottage food production operation to label foods sold to consumers in accordance with the statute in order make the public aware that food produced by a cottage food operation is not inspected by DSHS or a local health department (LHD). Additionally, the Legislature amends Chapter 437, Texas Health and Safety Code, which addresses farmers' markets. DSHS or a LHD may issue a temporary food establishment permit to a person who sells food at a farmers' market without limiting the number of days for which the permit is effective, with the maximum period of the permit being no more than one year.

**2013** – House Bill 1395 requires DSHS to initiate rulemaking efforts relating to the exemption of registered dental laboratories from certain distributing and manufacturing licensing requirements. Senate Bill 329 requires DSHS to implement changes to the tanning facility rules to prohibit a person younger than 18 years of age from using a tanning device in a tanning facility.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

As everyone consumes food, nearly everyone takes drugs, and many utilize medical devices, Food and Drug Safety impacts all citizens of Texas. In addition, licensure, inspections of regulated facilities and/or products, and enforcement of standards affect all persons who engage in any of the regulated activities.

Food and Drug Safety imposes restrictions on the eligibility for persons regulated under certain programs. These include certain felony convictions related to specific licenses by statute. For instance, a manufacturer or distributor of drugs may not employ or use in any capacity an individual with a conviction of a drug-related offense. DSHS must license regulated facilities to operate in Texas. For successful licensure, the facility must complete a multi-page license application properly and pay the required licensing fee. Additionally, in some programs, an applicant must undergo a pre-licensing inspection and pass a criminal background check prior to the issuing of a license. A license is valid for two years. For a facility to retain its license, the results of any inspections, along with follow-up visits, must show the facility to be in substantial compliance with the currently applicable state laws and rules.

| Number of Firms and Certifications Fiscal Year 2012 | |
|---|---|
| Food Manufacturers | 14,535 |
| Food Wholesalers | 1,627 |
| Food Warehouse Operators | 563 |
| Food Wholesale Registrants | 810 |

| Number of Firms and Certifications Fiscal Year 2012 | |
|---|---|
| Multiple Products (Food, Drug, Device)* | 2,055 |
| Drug Distributors (Prescription and Non-prescription) | 1,871 |
| Drug Manufacturer (Prescription and Non-prescription) | 381 |
| Device Manufacturers | 322 |
| Device Distributor | 1,321 |
| Food, Drug, and Device Salvage | 326 |
| Bottled and Vended Water (Machines) | 5,770 |
| Bottled and Vended Water (Operators) | 574 |
| Pseudo-Ephedrine Retailers Distributors | 23 |
| Tanning | 1,720 |
| Tattoo | 1,539 |
| Body Piercing | 886 |
| Retail Establishments (Including Mobile Food Units) | 12,023 |
| Producer Dairies | 603 |
| Milk Tankers | 821 |
| Pasteurization (Includes Out of State) | 43 |
| Frozen Desserts (Includes Out of State) | 74 |
| Milk Transfer/Receiving Station | 28 |
| Retail Raw | 65 |
| Non-Grade A | 82 |
| Seafood (Shellfish and Crab) | 68 |
| Meat Safety (Meat Establishments Facilities, Haulers, Renderers) | 353 |
| Meat Group Rendering Establishments | 86 |
| Meat Group Transfer Stations | 12 |
| Meat Group Related Stations | 1 |
| Meat Group Renderable Raw Material, Dead Animal, and | 143 |
| Meat Group Decals | 1,356 |
| Meat Group Construction Permit | 5 |
| Certified Food Managers (Certified at Test Sites) | 2,536 |
| Certified Food Manager Programs and Test Sites | 15 |
| Accredited Food Handler Programs | 23 |
| School Cafeteria Inspection Fee Applications Processed | 1,052 |

∗ Due to changes in reporting from the database, Food and Drug Safety cannot list the number of multiple product licenses by the specific types of products.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

RSD administers the Food and Drug Safety programs. RSD administers all activities from the Austin office and operates functionally with respect to policies and standards, compliance and enforcement, and licensure. Food and Drug Safety makes assignments to the field inspection staff according to risk. Field inspection staff returns completed inspection reports to the Austin office for review and determination of the need for any additional voluntary or formal regulatory action to protect public health. All field staff members located in DSHS health service regions (HSRs) are home-based or have duty stations in meat processing plants. Food and Drug Safety distributes field staff throughout the state, according to workload, under the direct supervision of the Austin office supervisors. The exception is sanitarians working for the Food Establishment Group; these staff members are supervised by the respective HSR directors.

Except for meat safety inspections, field staff forwards completed inspection reports to the Environmental and Consumer Safety Section, Policy, Standards, and Quality Assurance (PSQA) Unit; the PSQA Unit enters the reports into a central database. The PSQA Unit reviews the reports and recommends re-inspection or forwarding to the Enforcement Unit. The PSQA Unit also maintains and revises procedure handbooks to ensure compliance with state and federal mandates. The Environmental and Consumer Safety Section, MSA Unit conducts meat inspections and enters reports into the USDA Performance Based Inspection System.

Food and Drug Safety has a risk-based matrix to ensure that the establishments posing the highest risk receive the most attention through inspections and follow-up visits. Examples of criteria used to categorize the risk of an establishment include the inherent risk of the food being processed, the type of processing the food undergoes, the compliance history of the firm, the number of people served, and the kinds of individuals served (for example, the very young or the elderly, as opposed to all individuals). An example of a high-risk establishment is one that produces low acid canned foods; if the food is underprocessed, it could be contaminated with botulinum toxin. Establishments such as low risk food warehouses, manufacturers of low risk foods, and manufacturers and distributors of low risk medical devices and over-the-counter drugs no longer receive routine inspections, except for times when field staff is in an area and has the opportunity to conduct inspections.

Food and Drug Safety uses various authorities granted by law to gain compliance, including the detention and destruction of adulterated foods, drugs, and medical devices. The program may issue warning letters in an attempt to gain voluntary compliance following inspections where staff observes significant violations. When Food and Drug Safety is unable to obtain voluntary compliance, staff may proceed with formal enforcement actions. Food and Drug Safety uses enforcement review committees, composed of program representatives. These representatives review each case and the evidence documenting the continued violations to determine the type of formal action needed to obtain correction.

Both field and Austin office staff receive complaints against regulated industries and enter them into a central database, where staff assigns the complaints unique identification numbers. The program investigates complaints according to a risk matrix, based upon the risk to public health associated with the nature of the complaint, especially if illness or injury is imminent or has occurred.

Food and Drug Safety staff works closely with epidemiologists in the DSHS Disease Control and Prevention (DCP) Services Division, Infectious Disease Prevention Section, Infectious Disease Control Unit during investigations of food-borne illness outbreaks.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/regulatory.shtm

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $6,883,172 |
| General Revenue | $11,202,752 |
| General Revenue-Dedicated | $5,307,454 |
| Other | $3,388 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| DCP Services Division, Zoonosis Control Unit | The Zoonosis Control Unit has authority over zoonotic diseases that are transmissible to man. | Food and Drug Safety reports zoonotic diseases identified during pre-slaughter and/or post-slaughter examination of food animals both to Zoonosis Control and to the Texas Animal Health Commission (TAHC). |

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| FDA | FDA conducts inspections of many of the same industries regulated by DSHS and uses | FDA issues no licenses and only inspects businesses engaged in interstate commerce. FDA has only |

| Name | Similarities | Differences |
|---|---|---|
| | similar laws and regulations. | enough staff to inspect 2-3 percent of the regulated industries. FDA oversees but rarely inspects dairies or shellfish producers, as state programs conduct these inspections following federal standards. |
| USDA, FSIS | FSIS conducts on-site continuous inspections of meat and poultry processing facilities using federal laws and regulations. | DSHS MSA Unit inspects meat and poultry from federally amenable livestock species for intrastate commerce, while FSIS inspects products destined for interstate commerce. MSA also inspects meat and poultry from non-federally amenable livestock species for interstate commerce. |
| Local health jurisdictions | Local health jurisdictions inspect and permit retail food service establishments using ordinances that, in many respects, are identical to state regulations. | Home rule cities may adopt rules that are different or more stringent than state law and rules. DSHS only inspects retail facilities in areas of the state that are not under local inspection and permitting (188 counties). |
| Texas Commission on Environmental Quality (TCEQ) | TCEQ laws and regulations cover certain types of environmental problems that may relate to facilities inspected by Food and Drug Safety, such as public water supplies and fish contaminants. | TCEQ has no inspection authority over food, drug, or medical device facilities or products. |
| Texas Department of Agriculture (TDA) | TDA regulates shell eggs. | By amendment to the Texas Agriculture Code in 1999, TDA has authority over the quality of shell eggs, while DSHS has authority over the safety of shell eggs. TDA grades eggs, while DSHS checks the storage and temperature of the eggs for safety. |
| TAHC | TAHC oversees animal health in Texas, including the protection of livestock, wildlife, and pets from disease; and tests for the presence of bovine spongiform | The MSA Unit has joint responsibility with TAHC for the health of food animals and wildlife defined by law as “amenable” (acceptable for sale for human |

| Name | Similarities | Differences |
|---|---|---|
| | encephalopathy (BSE) – joint jurisdiction with the DSHS MSA Unit. TAHC ensures disposal of inedible materials from the slaughter and processing of livestock, while the MSA Unit has inspectional jurisdiction over similar materials sent to rendering facilities. TAHC protects human health from animal diseases that are transmissible to people. TAHC performs similar functions to the MSA Unit in areas and facilities not under DSHS jurisdiction. | consumption). MSA's jurisdiction begins at slaughter and ends at consumption, while TAHC's authority ends when the animal is brought to slaughter, as TAHC does not have jurisdiction in the slaughter plants other than periodically collecting blood samples. Both share responsibilities with respect to BSE. |
| Texas Parks and Wildlife Department (TPWD) | TPWD regulates hunting, fishing, and recreational activities in Texas. The DSHS Seafood Program collects information used by DSHS to establish safe harvest areas. TPWD enforces bans made by DSHS. TPWD has jurisdiction over indigenous game animals, such as white tail deer, for which the hunter must obtain a hunting license from TPWD. | The DSHS Seafood Program samples shellfish and finfish harvest areas. When DSHS declares seafood harvest areas prohibited, TPWD game wardens enforce the closure areas. |
| Office of the Texas State Chemist (OTSC) | OTSC regulates pet food products. The DSHS MSA Unit regulates renderable, raw materials, which includes unprocessed or partially processed inedible material of animal or plant origin that manufacturers may render into pet food. | The DSHS MSA Unit regulates inedible, renderable raw materials until manufacturers render the products. If, and when, the manufacturers render the inedible products into pet food, OTSC has jurisdiction of the product. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

Food and Drug Safety patterns all food, drug, and medical device safety, labeling, and efficacy requirements after federal law. Texas has adopted the majority of its rules by reference to federal requirements or adopted standards using federal regulations as models.

Food and Drug Safety coordinates inspections with the FDA to minimize duplication of inspections. Electronic access to each other's lists of establishments subject to inspection allows each agency to check for inspection assignments or pending regulatory actions. DSHS contracts with FDA to conduct inspections for FDA of establishments that FDA will not inspect. DSHS and FDA establish partnership agreements, whereby DSHS conducts inspections for FDA in exchange for other equipment, services, or training. These partnerships include inspections of food and drug imports, medical gases, over-the-counter drug manufacturers, and certain medical devices. A memorandum of understanding between FDA and DSHS outlines use of information and resource sharing to eliminate duplication and enhance consumer protection.

The USDA pays up to 50 percent of the costs of the state meat and poultry inspection program for inspections provided in establishments that slaughter federally amenable livestock species and/or process meat and poultry products from federally amenable livestock species to be sold in intrastate commerce. USDA also pays the State of Texas up to 50 percent of the costs (100 percent of the costs for reimbursable services) for DSHS inspections of "Talmadge-Aiken" (facilities that may legally ship in interstate commerce) meat and poultry processing facilities that USDA is unable to staff. Consequently, there is no duplication of services. Texas is recognized by USDA as an "equal to" state based upon complete annual (self-assessment) and tri-annual (self-assessment and on-site) programmatic audits by USDA.

The TAHC has jurisdiction over livestock before slaughter in a plant regulated by the DSHS MSA Unit; however, MSA staff contacts TAHC if MSA staff suspect that livestock brought into a slaughtering facility might have a zoonotic, communicable, or foreign animal disease. TAHC assists the MSA Unit veterinarians in sampling for diseases, quarantining animals, tracking an animal's history, and providing guidance on appropriate disposal of carcasses and parts of suspect animals. There is no duplication of services, but rather cooperation in areas of joint jurisdiction.

Chapter 437, Texas Health and Safety Code, limits DSHS inspections of retail food establishments to those establishments that are not under inspection and permit approval by local health jurisdictions. Local jurisdictions concentrate on the good sanitation practices, as outlined in the rules for Texas Food Establishments (Title 25, Texas Administrative Code, Chapter 229, Subchapter K).

The TCEQ contracts with the DSHS Seafood Safety Group to conduct sampling of fish from public waterways for heavy metals and other chemical adulterants. The Seafood Safety Group then analyzes the results of the samples and completes a risk characterization. Further, various laws and rules enforced by DSHS contain references to water source surveys conducted by TCEQ, rather than requiring the DSHS regulatory programs to duplicate these activities.

Amendments to the Texas Agriculture Code, following the TDA Sunset Review in 1997, eliminated any duplication that might otherwise occur between DSHS and TDA with food safety programs. In part, these stipulated that TDA have authority over shell egg quality (grading of the eggs) only, while DSHS has authority over the safety of shell eggs (temperature monitoring and inspection at wholesale and retail). In addition, TDA only promotes companies that have appropriate DSHS licensure under the "Go Texan" program. DSHS coordinates activities with TDA.

There is no duplication between DSHS and TPWD, but rather a cooperative effort, whereby DSHS issues fish advisories and sets limits on where the industry can harvest molluscan shellfish. TPWD establishes and enforces harvesting limits by the industry. TPWD has jurisdiction over indigenous game animals, such as white tail deer, for which the hunter must obtain a hunting license from TPWD.

There is no duplication between DSHS and OTSC, as OTSC jurisdiction begins where DSHS jurisdiction ends (i.e., when the previously inedible material of animal or plant origin has been rendered into the finished pet food product). DSHS coordinates with OTSC, as necessary, when either entity receives complaints concerning pet food products.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Rural school districts | Another DSHS program, Environmental Health, inspects schools, including school cafeterias, not located within the confines of a local public health jurisdiction; however, Environmental Health sends the inspection reports to the Food Establishments Group in Food and Drug Safety for review. | DSHS inspects the schools, including the cafeterias. |
| Local health jurisdictions | Local health jurisdictions inspect and permit retail food service establishments. Some jurisdictions also test and issue certificates to food service managers. | Food and Drug Safety provides training to local health jurisdictions, including standardization of local inspectors to ensure uniform inspections. Food and Drug Safety works jointly with local jurisdictions on food-borne illness investigations and assists local health jurisdictions |

| Name | Description | Relationship to DSHS |
|---|---|---|
| | | with the adoption and update of their local ordinances. DSHS serves as a model to the local jurisdictions in the inspection and enforcement of retail food safety laws and rules. DSHS staff gives numerous presentations to local and state groups of sanitarians. |
| Municipal public health laboratories | Municipal public health laboratories analyze both clinical and public health-related samples, usually submitted from within their own jurisdictional boundaries. | The Milk and Dairy Group contracts with the larger municipal laboratories in Texas to conduct bacteriological and antibiotic residue analyses of over 131,000 samples each year. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| FDA | FDA oversees all food safety in the United States other than meat and poultry, sets standards, approves food additives, and approves new drugs and medical devices. FDA also oversees importation of these food and drug products. | DSHS administers state laws and regulations that, in most cases, are identical to those enforced by FDA. DSHS looks to FDA for advice on approved food additives and approval of new drugs and devices. DSHS shares lists of regulated establishments with FDA and conducts inspections for FDA. FDA audits inspections DSHS conducts for FDA and the qualifications of DSHS inspectors. FDA also oversees the work of the Milk and Dairy Group and the Seafood Group, which must meet specific standards in order for Texas producers to ship their products in interstate commerce. FDA also provides model standards for the Food Establishments Group (retail). |
| USDA, FSIS | FSIS inspects all amenable species of livestock, meat, and poultry, listed as subject to federal inspection, that are scheduled for interstate | DSHS receives 50 percent of program funding from FSIS and receives program audits by FSIS to ensure that the state Meat Safety inspections remain “equal to” the |

| Name | Description | Relationship to DSHS |
|---|---|---|
| | shipment. FSIS establishes all regulations dealing with the safety and labeling of amenable species of meat and poultry, regulations that are preemptive upon the states. | federal meat and poultry inspection standards. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

DSHS established contracts in this program for the following:
- milk and dairy sample laboratory analysis,
- fish and shellfish tissue laboratory analysis,
- rapid response team for food-borne outbreak, and
- food processing and technology course training.

Amount of contracted expenditures in fiscal year 2012: $853,331
Number of program contracts: 26 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $173,968 | Tarrant County | Milk and dairy laboratory sample analysis |
| $90,630 | Northeast Texas Public Health District | Milk and dairy laboratory sample analysis |
| $78,363 | Texas Agrilife Research | Support for RRT cooperative agreement grant from USDA |
| $47,422 | City of San Antonio | Milk and dairy laboratory sample analysis |
| $45,576 | City of Houston | Milk and dairy laboratory sample analysis |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes

edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs targeted financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. Assigned contract managers use an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring of reports. DSHS has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

The program does not award grants.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory changes to assist the program in performing its functions.

**Chapter 431 and 437, Texas Health and Safety Code** – DSHS recommends revision to provide DSHS with authority to suspend a license issued under these chapters for repeated serious violations without the prerequisite that the violations pose an imminent health hazard.

**Section 431.021, Texas Health and Safety Code** – DSHS recommends revision to make it a violation for a flea market operator to allow the sale of illegal foods, drugs, or medical devices from the premises under the operator's control.

**Section 431.048, Texas Health and Safety Code** – DSHS recommends revision to reference the administrative penalty option for contested cases.

**Section 38.15, Texas Penal Code** – DSHS recommends revision to add additional protection of inspectors in health-related fields from physical abuse and/or verbal abuse and threats.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**
- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**

- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Regulation of the persons licensed, certified, and inspected by Food and Drug Safety is necessary for the protection of health and safety of the citizens of Texas and the citizens of the United States with respect to products sold in interstate commerce.

Food and Drug Safety operates within the parameters established by statute and according to rules adopted to enforce these laws. Where possible, Food and Drug Safety uses uniform procedures for conducting inspections, including report forms, evidence development, and review of reports. Each area utilizes a risk assessment procedure to determine inspection frequency. Areas utilize procedure manuals for directing the activities of the inspection staff and, in a number of cases, also use federal procedure manuals to maintain uniformity with federal counterparts.

When Food and Drug Safety observes non-compliance, the program may implement one or more of the following: place establishments on escalated re-inspection frequencies; issue warning letters; and/or voluntarily destroy or place adulterated foods, drugs, and devices under embargo. Statutes and rules do not allow livestock slaughter and meat and poultry processing facilities to operate and/or enter their products into commerce on a daily basis, unless the inspector-in-charge at the facility finds them in compliance. Many of the areas within Food and Drug Safety have embargo authority to remove adulterated and significantly misbranded foods, drugs, and devices from commerce and destroy adulterated foods and drugs, as well as obtain summary closure of a facility in the case of the existence of an imminent health hazard.

Food and Drug Safety has a risk module for handling consumer complaints, which requires investigating concerns involving illness or injury within 24 hours. Staff enters all complaints into a database for tracking and assignment. DSHS forwards complaints related to entities not under DSHS direct jurisdiction, such as those against restaurants or grocery stores, to the appropriate jurisdiction for investigation. Staff forwards those received from prison inmates to the Texas Department of Criminal Justice for investigation.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

| Department of State Health Services<br>Food and Drug Safety<br>Exhibit 11: Information on Complaints Against Regulated Persons or Entities<br>Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| Total number of regulated persons | 13,638 | 3,110 |
| Total number of regulated entities | 51,770 | 50,807 |
| Total number of entities inspected | 17,937 | 18,786 |
| Total number of complaints received from the public* | 1,443 | 1,340 |
| Total number of complaints initiated by agency | 143 | 75 |
| Number of complaint investigations pending from prior years | 95 | 130 |
| Number of complaints found to be non-jurisdictional | 94 | 110 |
| Number of jurisdictional complaints found to be without merit | 537 | 674 |
| Number of complaints resolved | 1,144 | 856 |
| Average number of days for complaint resolution | 313 | 400 |
| Complaints resulting in disciplinary action:** | | |
| administrative penalty | 66 | 64 |
| reprimand | 0 | 0 |
| probation | 0 | 0 |

* Represents all complaints received, including public, external sources, and internal sources.

** Because staff takes the majority of disciplinary actions as the result of routine inspections, reporting only disciplinary actions as a result of complaints would provide an inaccurate picture of the total disciplinary actions taken.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Environmental Health |
| **Location/Division** | 8407 Wall Street, Austin - Regulatory Services Division (RSD) |
| **Contact Name** | Kathryn C. Perkins, Assistant Commissioner, RSD |
| **Actual Expenditures, FY 2012** | $7,125,585 |
| **Number of Actual FTEs as of June 1, 2013** | 108.9 |
| **Statutory Citation for Program** | Chapters 141, 341, 343, 345, 385, 485, 501-502, and 505-507, Texas Health and Safety Code; Chapters 1954, 1955, and 1958, Texas Occupations Code; Sections 2165.301-2165.305, Texas Government Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

The Environmental Health Program has as its primary objective to design and implement risk assessment and risk management regulatory programs for consumer products, occupational and environmental health hazards, and public health sanitation. Major activities include the following.

**Asbestos Program**

The Asbestos Program conducts licensing, inspections, and enforces state and federal rules and statutes pertaining to asbestos in public buildings, schools, and commercial and industrial facilities. The Asbestos Program operates through fees generated from licensing and abatement notifications. Through federal grants administered by the U.S. Environmental Protection Agency (EPA), the Asbestos Program enforces the asbestos National Emission Standard for Hazardous Air Pollutants, dedicated to ensuring safe removal of asbestos in facilities, and the Asbestos Hazard Emergency Response Act, which applies to management of asbestos materials in schools.

**Abusable Volatile Chemicals Program**

The Abusable Volatile Chemicals Program provides for licensure, inspection, outreach and education, and enforcement of rules and statutes pertaining to restriction of minors from purchasing inhalant-abuse products and to proper signage for retail establishments that sell abusable volatile chemicals. The Abusable Volatile Chemical Program operates through fees generated from permitting of retail facilities that sell regulated products.

**Bedding Program**
The Bedding Program provides for licensure, inspection, outreach and education, and enforcement of rules and statutes pertaining to new, remanufactured, and used bedding products to ensure the health and safety of the consumer. Regulations provide the consumer with a safe, properly manufactured and labeled bedding product, and sanitary conditions in manufacturing plants and germicidal treatment facilities. The Bedding Program operates through fees generated from licensing of bedding manufacturers and germicidal treatment operators.

**Hazardous Products Program**
The Hazardous Products Program conducts licensing, inspections, and enforces rules and statutes pertaining to consumer products to ensure that manufacturers and others inform consumers of product hazards and label products properly, including children's products regulated by the U.S. Consumer Product Safety Improvement Act. The Hazardous Products Program operates through fees generated from registration of manufacturers, repackagers, and private label distributors of consumer products.

**Environmental Lead Program**
The Environmental Lead Program certifies, inspects, and enforces rules and statutes to ensure safe work practices for controlling hazards of lead-based paint. The program operates with fees generated through licensing, abatement notifications, and a federal grant administered by the EPA.

**Environmental Home Investigations Program**
The Environmental Home Investigations Program provides public assistance and conducts field investigations in homes of children with elevated blood lead levels. Upon conclusion of the investigation, the program notifies the medical provider, parent, and homeowner of potential sources of lead as well as recommendations to mitigate the exposure of the child to environmental lead. DSHS relocated the program to the Prevention and Preparedness Services Division (now the Disease Control and Prevention Services Division) in 2010, and the environmental health strategy is providing funding for positions on a temporary basis until fully funded by Medicaid reimbursement.

**Community Right to Know (Tier II Chemical Inventory Reports) Program**
The Community Right to Know Program conducts inspections and enforces rules relating to the requirement to submit annual reports of hazardous chemical inventories (called Tier II Chemical Inventory Reports) to ensure that chemical manufacturers inform the public, and to facilitate emergency response planning. The Community Right to Know Program operates through fees generated from submission of the Tier II Chemical Inventory Reports.

**Worker Right to Know (Hazard Communication for Public Employers) Program**
The Worker Right to Know Program provides for outreach, inspection, and enforcement of the Texas Hazard Communication Act. This act requires public employers to develop and maintain a written hazard communication program and provide information and training to employees

who routinely work with hazardous chemicals in the workplace. The Worker Right to Know Program operates through fees generated from Tier II Chemical Inventory Reports submitted under the Community Right to Know Program as allowed by statute.

**Public Health Sanitation Program**

The Public Health Sanitation Program provides complaint investigations and enforcement of public health nuisances as allowed by statute in areas of the state without a local health department (LHD) for the following conditions: breeding places for flies in a populous area, rat harborage in a populous area, and conditions or places that can transmit disease to or between humans.

**Public Pools and Spas Program**

The Public Pools and Spas Program performs complaint investigations of public swimming pools and spas for compliance with minimum construction, operation, safety, and maintenance standards in areas of the state without a LHD. Local law enforcement officials make referrals for the enforcement of the public pool and spa rules.

**Public Interactive Water Features Program**

The Public Interactive Water Features Program performs complaint investigations of public interactive water features for compliance with sanitation and safety standards and for enforcement by closure in areas of the state without a LHD.

**Economically Distressed Area Program (EDAP)**

The EDAP investigates water and wastewater services in economically distressed areas. According to Section 17.933, Texas Water Code, DSHS functions in an investigatory manner to determine if a nuisance dangerous to the public health and safety exists as defined by Section 341.011, Texas Health and Safety Code. If DSHS finds a public health nuisance, the area may be eligible for federal funding to install or repair public sanitation equipment, such as wastewater treatment facilities.

**Mold Remediation Program**

The Mold Remediation Program conducts licensing and inspections and enforces rules and statutes relating to mold remediation projects to ensure that consumers receive services that meet regulatory standards. The Mold Program operates through fees generated from licensing and notifications submitted for mold remediation projects.

**Youth Camps Program**

The Youth Camp Program provides for licensure, inspection, outreach and education, and enforcement of rules and statutes pertaining to youth camps. The program ensures safe facilities and practices for the lodging, feeding, daily activities, and care of children. Youth camp inspections may cover multiple components of the youth camp facility, including swimming pools, public interactive water features, food service facilities, playgrounds, and private water supplies. The Youth Camp Program operates through fees generated from the licensing of youth camps.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

With the functional alignment of activities as described in Question E, the Environmental Health Program accomplishes a variety of environmental inspections using common resources, including personnel and equipment. As a result of the increase in efficiency, DSHS has improved access to the regulated community, shortened response times, fostered consistencies in enforcement, and increased regulatory coverage. DSHS demonstrates evidence of this increase in efficiency by the numbers of inspections conducted before and after functional alignment. In fiscal year 2004 (prior to the reorganization), centrally directed programs in Environmental Health conducted 11,008 inspections. During the first year of the reorganization, the number of inspections did not significantly change (10,973), but in fiscal year 2006, the centrally directed programs conducted 15,594 inspections.

| Centrally Directed Inspections by Fiscal Year | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **FY 2004** | **FY 2005** | **FY 2006** | **FY 2007** | **FY 2008** | **FY 2009** | **FY 2010** | **FY 2011** | **FY 2012** |
| 11,008 | 10,973 | 15,594 | 19,495 | 13,593 | 13,417 | 13,297 | 12,291 | 12,124 |

Cross-utilization of personnel in the inspection program was a primary factor in increased number of inspections from 2005 to 2007. For example, asbestos inspectors conducted abusable-volatile-chemical (AVC) inspections while on travel status to investigate asbestos complaints. In addition, environmental health inspectors received training to conduct bedding, AVC, and product safety inspections.

In fiscal years 2006 and 2009, these new efficiencies were evident as citizens were repatriating housing facilities in the aftermath of hurricanes Rita, Katrina, and Ike. On an emergency basis, DSHS assisted federal and local governments by ensuring safe living conditions for residents returning to impacted areas and for those transferred to alternative housing. During one 6-week period, DSHS' environmental inspectors in the affected area conducted over 600 housing inspections in addition to routine inspections conducted under other environmental programs. In addition, the RSD's environmental health technical expert served as a liaison for the Centers of Disease Control and Prevention (CDC), Federal Emergency Management Administration, U.S. Fish and Wildlife Service, and U.S. Department of Defense in the assessment of vector problems in the affected areas. This measure enabled federal, state, and local resources to provide aerial spraying needed to reduce the proliferation of mosquitoes that hampered recovery efforts and to prevent the spread of mosquito-borne illnesses, such as St. Louis encephalitis and West Nile infection, after heavy rains and flooding from Hurricane Ike.

The above examples demonstrate that the consolidation of programs into functional units provides the opportunity to expand Environmental Health's risk matrix to assess the needs of the public on a broader scale and provide public health services more efficiently. As such, the

program applies the risk-based approach to prioritize all functional activities, rather than limiting the prioritization to within each discrete activity.

The Environmental Health Program has implemented further improvements in program efficiency with the application of the Regulatory Automated System (RAS). This system replaces outdated and obsolete databases designed for specific functions in each regulatory program. The new system provides authorized Environmental Health employees with real-time access to licensing, enforcement, and inspection data. This innovation reduces the personnel time required to extract and utilize information for the benefit of the public. The Environmental Health Program has recently implemented online systems for the provision of public access to information and license renewals. This measure has increased licensing efficiency by reducing the staff time required to process applications.

In 2011 and 2012, a retraction in program size and capabilities due to staff reductions and a reassessment and redirection of inspection resources contributed to the decrease in the number of inspections for centrally directed programs in the Environmental Health Program. The program refocused inspection resources to areas with clear DSHS obligations and elevated risk to public health.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**2001** – The legislatively mandated Business Practices Evaluation Report of 2001 finds that the Texas Department of Health needs a complete reordering of the administrative and organizational infrastructure in order to function efficiently. In response to findings, Environmental Health undergoes staff reorganizations that centralize inspection teams within programs and combines certain programs according to functionality.

**2003** – The Legislature passes three bills that add or change functions in Environmental Health. Senate Bill 329 directs DSHS to initiate a new program to regulate mold remediation. The Mold Program ensures that DSHS properly trains, licenses, and ensures adherence to work-practice standards with companies and individuals performing regulated mold remediation activities. Senate Bill 599 transfers the responsibility for conducting indoor air quality investigations in state facilities from the Texas Building and Procurement Commission to DSHS. This change eliminates redundancies between the two agencies, but increases the scope of activities for Environmental Health. House Bill 2292 requires a two-year term for each license issued by DSHS, with the exception of youth camp licenses that require a one-year term. In addition, this law requires DSHS to charge licensing fees in amounts necessary to recover from its license holders all necessary costs to administer and enforce the program.

**2004** – DSHS undergoes further reorganization, creating functional units dedicated to inspections, enforcement, and licensing activities. This new functional structure consolidates

programmatic responsibilities to a unit dedicated to policy development, standards, and quality assurance. This reorganization improves availability of services to the regulated community and helps standardize quality assurance across programs.

**2009** – Senate Bill 968 authorizes DSHS to begin regulating sanitation at interactive water features and fountains and to adopt rules for the new program.

**2010** – Environmental lead investigations become a Texas Medicaid benefit for Texas Health Steps clients with an elevated blood level demonstrating medical necessity. The program locates in another division, but the environmental health strategy is providing funding for positions on a temporary basis until fully funded by Medicaid reimbursement.

**2011** – Senate Bill 1414 authorizes DSHS to implement a requirement for training and examination programs on warning signs of sexual abuse and child molestation for employees of higher education campus programs hosting children.

**2012** – The Environmental Health strategy previously provided food service sanitation inspections upon request from childcare facilities in areas of the state without a LHD. Environmental Health transfers this inspection activity to the Texas Department of Family and Protective Services and notifies childcare facilities of the change.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

The Environmental Health Program performs activities that protect public health and consumers of products, impacting most people in Texas either directly or indirectly. The qualifications and eligibility requirements for persons and entities holding licenses vary according to statute. Licenses that qualify the license holder to conduct or oversee projects involving hazardous materials require specialized training, formal education, and relevant work experience. The table below represents the combined numbers of individuals and firms holding licenses, certifications, or permits.

| Program | Holders of Licenses, Certificates, or Permits in Fiscal Year 2012 |
|---|---|
| Asbestos | 7,078 |
| Environmental Lead | 1,009 |
| Mold | 3,777 |
| Youth Camps | 546 |
| Abusable Volatile Chemicals | 22,461 |
| Hazardous Products | 1,252 |
| Bedding | 4,939 |
| **Total** | **41,062** |

Additionally, RSD received 63,579 Tier II Chemical Reports during fiscal year 2012.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

RSD administers the Environmental Health Program and organizes the program functionally into the Environmental and Consumer Safety Section, which includes the Policy, Standards, and Quality Assurance (PSQA) Unit and the Inspection Unit, and the Health Care Quality Section, which includes the Regulatory Licensing Unit. The Enforcement Unit and the health service regional inspectors are also in the Environmental Health Program. The PSQA Unit coordinates activities that facilitate policy development, rule interpretation, legislative inquiry, standards development, quality assurance, grants, contracts, and program accountability. The PSQA Unit performs these activities with input and direct interaction with experts from each of the other functional units.

The Regulatory Licensing, Inspection, and Enforcement Units each have designated groups for performing their respective duties within the Environmental Health Program. In the Inspection Unit, the Notifications Group performs the administrative functions of receipt of project notifications; data entry; sorting; and disseminating of information on asbestos, lead, and mold abatement projects for the facilitation of inspection scheduling and prioritization. This function is integral to the risk assessments used in each abatement program. In addition, the Notifications Group receives and processes notification fees collected under each abatement program.

Centrally directed inspectors conduct inspections for the following programs: Asbestos, Abusable Volatile Chemicals, Bedding, Hazardous Substances, Environmental Lead, Community Right to Know, Worker Right to Know, and Mold Remediation. Staff conducts the inspections in accordance with a risk assessment designed for each activity in order to provide a fair, consistent, and effective compliance approach within the regulated community. Inspectors report these activities weekly to the Inspection Unit. Thereafter, staff turns in all associated paperwork, such as checklists, sample results, and report narratives, within timelines prescribed by each activity. Group managers in the Inspection Unit receive and review the work according to standards prior to forwarding to the PSQA Unit. Specialists in the PSQA Unit review the findings of each inspection to determine whether to proceed with enforcement action; if so, specialists forward the recommendation to the Enforcement Unit. The Enforcement Unit, with support from the Office of General Counsel, handles the due process requirements associated with prosecuting cases.

Regionally directed inspectors who report to the DSHS health service region directors conduct inspections for the following programs: Public Health Sanitation, Public Pools and Spas, Public Interactive Water Features, Public Schools and School Cafeterias, EDAP, and Youth Camps. Staff conducts inspections in accordance with policies, procedures, and risk-management criteria

administered through the PSQA Unit in Austin. The regionally directed inspectors submit reports to the PSQA Unit for review and possible referral to the Enforcement Unit.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/regulatory.shtm

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $1,006,313 |
| General Revenue | $3,367,834 |
| General Revenue-Dedicated | $2,626,438 |
| Other | $125,000 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| EPA | EPA administers and enforces federal asbestos regulations. | EPA serves as an oversight agency to DSHS. EPA performs limited numbers of asbestos compliance inspections. |
| Texas Commission on Environmental Quality (TCEQ) | TCEQ administers and enforces asbestos (waste) regulations pertaining to landfill requirements. | DSHS has jurisdiction over asbestos abatement projects but not the landfill requirements that result from those projects. |
| Texas Water Development Board (TWDB) and TCEQ | TWDB and TCEQ administer the EDAP. | DSHS conducts the required inspections, while TWDB and TCEQ provide oversight and funding. |
| Occupational Safety and Health Administration (OSHA) | OSHA is involved in enforcement of regulations regarding field sanitation in places of temporary employment. | DSHS only has jurisdiction in work areas that have less than 11 employees; OSHA has jurisdiction in areas having 11 or more employees. |
| U.S. Consumer Product Safety | CPSC administers and enforces federal hazardous substance | DSHS requires hazardous substance manufacturers, |

| Name | Similarities | Differences |
|---|---|---|
| Commission (CPSC) | labeling requirements. | repackagers, distributors, and importers to register and pay fees prior to distributing products in the state. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

The Environmental Health Program works closely with its federal partners to ensure program policies and procedures are consistent at the state and federal level and to remove duplication of effort. The EPA shares regulatory clarifications and policy interpretations with Environmental Health staff and holds meetings as needed to ensure staff uphold the federal intent of the asbestos and lead regulations. DSHS submits progress reports to EPA as part of its asbestos and environmental lead grant requirements that facilitate communication of program activities. EPA delegated separate portions of the federal asbestos regulation to DSHS and to the TCEQ, so the agencies generated a memorandum of understanding between TCEQ and the legacy Texas Department of Health to outline their respective responsibilities and prevent duplication. Similarly, DSHS works closely with other state agencies in programs involving overlapping jurisdictions. In EDAP, for example, DSHS limits its activities to performing site investigations, while the TWDB and TCEQ perform administrative and funding activities.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| LHDs | Local agencies provide healthcare services to their respective constituents. | DSHS performs public health sanitation inspections only in areas where there is no capability through a LHD. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| EPA | DSHS performs asbestos and environmental lead activities under grants from EPA. | EPA administers the grants and serves as an oversight agency to DSHS. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The program does not have any contracts.

**L. Provide information on any grants awarded by the program.**

The program does not award grants.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory changes to assist the program in performing its functions.

**Chapter 502, Texas Health and Safety Code (Texas Hazard Communication Act)** – DSHS recommends a revision to update the definition of "hazardous chemical" and "material safety data sheet" in the Act for consistency with newly revised definitions in the OSHA's Hazard Communication Standard, codified as 29 Code of Federal Regulations, Section 1910.1200.

**Chapters 505, 506, and 507, Texas Health and Safety Code** – DSHS recommends deleting the provision in all four statutes that allows non-compliant entities, including repeat offenders, as many as three opportunities to come into compliance before DSHS can take any action. Because of these provisions, DSHS has never assessed an administrative penalty for violations of these statutes. DSHS finds approximately one-third of all facilities covered by the Emergency Planning and Community Right-to-Know Act (EPCRA) Tier II that are inspected annually out of compliance by failing to notify their local fire departments, emergency planning committees, and DSHS of their potentially hazardous chemicals as required. This revision will enable DSHS to collect penalty fees for first-time violations, a percentage of which DSHS can provide as grants to local emergency planning committees to assist them in fulfilling their responsibilities under EPCRA.

**Chapter 505, Texas Health and Safety Code (Manufacturing Facility Community Right-To-Know Act)** – DSHS recommends a change in the amount of available administrative penalties from $500 maximum per violation per day (not to exceed $5,000 for each violation) to up to $5,000 per violation per day, to provide DSHS with more discretion in assigning penalties.

**Chapter 507, Texas Health and Safety Code (Non-manufacturing Facilities Community-Right-To-Know Act)** – DSHS recommends a revision to the amount of available administrative penalties from $50 maximum per violation per day (not to exceed $1,000 for each violation) to up to $1,000 per violation per day to provide DSHS with more discretion in assigning penalties.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

The Environmental Health Program is broad in scope and continues to grow with an increasing number of programs and licensees. The program is founded on a variety of statutes and regulations that share the objective of protecting the citizens from harm in the areas of hazardous materials and consumer products. These statutes and regulations are essential for ensuring compliance with the health, safety, and consumer protection standards developed by DSHS and its oversight agencies. DSHS establishes eligibility requirements for licensing, certification, and training in accordance with state and/or federal statutes to protect the public from exposure to hazardous materials and provide the consumer access to professional services of the highest possible standards.

The Environmental Health Program bases inspection activities on a risk assessment to ensure the utilization of allocated resources for maximum benefit to health, safety, and consumer protection. The program develops standardized inspection methodology for each activity, including the use of standard forms, checklists, and attachments necessary to document the findings of each type of inspection. Initial and recurring training for all inspectors reinforces this methodology and ensures that staff conducts inspections consistently across the regions of the state.

Staff completes inspections and audits of license holders and regulated abatement projects on a routine basis or in response to a complaint, tip, or referral. Internal or external sources provide information to the PSQA Unit that, upon review, requests the Inspection Unit to

conduct an investigation of a regulated project or a license holder's activities to determine compliance with applicable regulations.

Compliance history is an important criterion used in prioritizing inspections in the programs involving abatement of hazardous materials. This information consistently and reliably directs the inspection staff to conduct follow-up inspections of violators. Although the conditions surrounding a previous violation may no longer exist, follow-up inspections are important to assess the licensee's progress in complying with all of the regulations pertinent to the license.

Staff also performs follow-up inspections in facilities under consumer product regulations as determined by the facility's compliance history. Environmental Health balances the decision to conduct follow-up inspections in these programs with the need for the program to have broad coverage in many different retail facilities. Staff considers the compliance history and the risk to the public when deciding to conduct follow-up inspections at specific establishments.

The Environmental Health Program seeks to ensure compliance through a balance of compliance assistance and enforcement actions. Overall, Environmental Health operates under an enforcement policy that uses the minimum necessary sanctions to achieve the compliance objective. Sanctions may include detention and destruction of products, administrative penalties, and license suspension and/or revocation as well as referrals for civil and criminal prosecution.

The Environmental Health Program gives complaint investigations top priority and investigates these within the timelines of the applicable statute. The PSQA Unit serves as a repository to the public for complaint intake; however, personnel within all functional units may receive and refer complaints when called upon. The PSQA Unit maintains a complaint log to monitor timeliness responses to complaints.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

**Department of State Health Services**
**Environmental Health**
**Exhibit 11: Information on Complaints Against Regulated Persons or Entities**
**Fiscal Years 2011 and 2012**

| | FY 2011 | FY 2012 |
|---|---|---|
| Total number of entities inspected * | 20,240 | 18,709 |
| Total number of complaints received from the public | 457 | 396 |
| Total number of complaints initiated by agency** | 2,823 | 2,528 |
| Number of complaints pending from prior years*** | 85 | 27 |
| Number of complaints found to be non-jurisdictional*** | 17 | 5 |

| Department of State Health Services<br>Environmental Health<br>Exhibit 11: Information on Complaints Against Regulated Persons or Entities<br>Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| Number of jurisdictional complaints found to be without merit*** | 203 | 174 |
| Number of complaints resolved*** | 330 | 271 |
| Average number of days for complaint resolution*** | 194 | 159 |
| Complaints/inspections resulting in disciplinary action:**** | | |
| administrative penalty | 660 | 695 |
| reprimand | 0 | 0 |
| probation | 1 | 0 |
| suspension | 0 | 0 |
| revocation | 0 | 0 |
| other | 470 | 114 |

* The regulated community far exceeds the total number of licensees within the programs. It includes all retail facilities, schools, construction projects, demolition projects, certain workers, employers, and owners of businesses, facilities, and Health and Human Service System agencies. Some of the regulated entities are under DSHS' jurisdiction only for the duration of an activity, for example, during a mold remediation project or the demolition of a structure.

** Complaints initiated by the agency include program-generated complaints resulting from inspections that reveal deficiencies.

*** These measures represent complaints received from the public.

**** Because staff implements the majority of disciplinary actions as the result of routine inspections, reporting only disciplinary actions taken as a result of complaints would provide an inaccurate picture of the total disciplinary actions taken.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Radiation Control |
| **Location/Division** | 8407 Wall Street, Austin - Regulatory Services Division (RSD) |
| **Contact Name** | Kathryn C. Perkins, Assistant Commissioner, RSD |
| **Actual Expenditures, FY 2012** | $7,815,605 |
| **Number of Actual FTEs as of June 1, 2013** | 125.8 |
| **Statutory Citation for Program** | Chapter 401, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Radiation Control has the following primary objectives.

- Design and implement a risk assessment and risk management regulatory program for all sources of radiation.
- Protect and promote public health and safety through a comprehensive program of regulation, education, and enforcement to minimize unnecessary radiation exposure to the public, radiation workers, and releases into the environment.

Major activities include the following.

**Radioactive Materials Licensing and Inspection**

RSD staff licenses, sets standards, inspects, and takes enforcement actions for users of radioactive material at medical, industrial, educational, and research facilities. They also conduct incident and complaint investigations. For regulation of these radioactive materials, the DSHS program must be compatible to that of the U.S. Nuclear Regulatory Commission (NRC) since the Governor of Texas entered into an agreement with NRC in 1963 whereby the federal government relinquished authority over certain radioactive materials to the State. Texas became what is called an “agreement state” when the Governor entered into this agreement.

**X-ray and Laser Program**

RSD staff registers the use of x-ray machines and lasers; and inspects the users of these sources of radiation at medical, industrial, educational, entertainment, and research facilities and for aesthetic treatment. This includes registration and inspection of laser hair-removal facilities and certification of individuals who perform laser hair-removal procedures. Staff also conducts incident and complaint investigations.

**Radiological Emergency Response and Preparedness**
RSD staff prepares and updates Annex D to the State of Texas Emergency Management Plan and prepares site-specific radiological emergency response plans. Additionally, staff conducts Federal Emergency Management Agency (FEMA)-graded full-scale exercises at the state's two nuclear utility facilities and the U.S. Department of Energy (DOE) nuclear weapons facility, Pantex. Staff conducts environmental monitoring around major radioactive material use facilities and investigations of radiological accidents and complaints. Staff also provides some radiological emergency response training to first responders in local governments; provides the responders with radiation detection instruments, such as Geiger counters; and provides radiological response support for state emergency operations.

**Mammography Facility Certification and Accreditation Programs**
The Mammography Facility Certification and Accreditation Programs certify and accredit mammography facilities and inspect these facilities in accordance with the requirements in state law and of the U.S. Food and Drug Administration (FDA), Mammography Quality Standards Act.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

Radiation Control works closely with other federal agencies to evaluate the effectiveness and efficiency of activities.

NRC audits the radioactive material regulatory program to assure adequacy and compatibility with the federal requirements. During a routine program review in February 2010, NRC found DSHS' radiation program to be "adequate to protect public health and safety" and "satisfactory" in all areas. Radiation Control has been a national leader in the regulation of radiation and had always received NRC's highest rating of "satisfactory" except when, in the early 2000s, the loss of many technical staff due to non-competitive salaries caused NRC to put the state under heightened oversight. Radiation Control greatly improved its performance after filling all technical staff vacancies. The Legislature's creation of a new classification of "health physicist" and the resulting salary increase helped DSHS to fill the vacancies. Radiation Control also modified the inspection program and placed more emphasis on timely reporting of incidents involving radioactive materials to NRC. The next NRC program review will occur in 2014.

Radiation Control has completed successful full-scale emergency response exercises, graded by the Federal Emergency Management Agency (FEMA), at the state's two nuclear utility facilities every year for the past 12 years. These exercises validate training of emergency response team members and include a demonstration of specific evaluation areas identified by FEMA. FEMA issues findings in the form of a final report on the evaluation of each area.

The FDA, Division of Mammography Quality Radiation Program granted the legacy agency Texas Department of Health (TDH) approval as an accreditation body in April 1999. Texas joined two other states (Arkansas and Iowa) and the American College of Radiology as approved accreditation bodies. FDA has approved the agency to accredit mammography units that utilize film-screen mammography, full-field digital mammography, and computed radiography mammography. The FDA provides oversight to the Mammography Accreditation Program by performing an annual evaluation; Texas has successfully passed the FDA performance evaluation for the past nine years.

The FDA approved the State of Texas as a Certifying Agency under the Mammography Quality Standards Act (MQSA) States as Certifiers provision, effective September 1, 2008. The FDA delegates many aspects of the MQSA certification program to qualified states that have applied for and received FDA approval as a certifying body. The FDA provides oversight to the Mammography Certification Program by performing an annual evaluation of the State of Texas Certifying Agency Program. The Mammography Certification Program successfully passed the performance evaluation conducted by the FDA in 2012. DSHS adequately and appropriately fulfills its responsibilities as an FDA-approved Certifying Agency.

Radiation Control also uses key statistics to evaluate program activities, such as the inspection of x-ray facilities. The number of new x-ray facilities has steadily grown as the Texas economy improved. As of May 31, 2013, DSHS had inspected 2,956 x-ray facilities, leaving an additional 3,571 x-ray inspections due. Because of the growing numbers of facilities that are subject to regulation and the static number of inspectors, regulatory programs have developed a risk-based matrix to ensure that the licensees and registrants posing the highest risk receive the most attention through inspections and follow-up visits.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1947** – The legacy agency TDH first becomes involved in radiological health activities. TDH conducts one of the nation's first extensive surveys demonstrating the radiation hazards of shoe-fitting fluoroscopes. In the early 1950s, TDH conducts a series of short courses on radiological hazards at various locations throughout the state.

**1961** – The Legislature adopts the Texas Radiation Control Act, codified as Chapter 401, Texas Health and Safety Code. The Act establishes the Texas Radiation Advisory Board and designates TDH as the Radiation Control Agency.

**1963** – An agreement between the Governor of Texas and the U. S. Atomic Energy Commission becomes effective. Under the agreement, Texas assumes all licensing and regulatory authority over radioactive materials in the state, with the exception of special nuclear material in excess of a critical mass and radioactive material utilized by federal agencies.

**1981** – The Legislature passes legislation allowing TDH to regulate uranium mill tailings and low-level radioactive waste and creates the Radiation and Perpetual Care Fund. The legislature designates the fund primarily for financial security that is required of uranium and low-level radioactive waste licensees. The Legislature also creates the Bureau of Radiation Control with an additional 100 staff to regulate all sources of radiation.

**1989** – The Legislature revised Chapter 401, Texas Health and Safety Code (Texas Radiation Control Act), to establish the regulatory framework and authority for the state agencies that regulate sources of radiation, encompassing the use, possession, and disposal of such sources.

**2001** – Since the terrorist attacks on September 11, 2001, the security of radioactive sources experiences heightened awareness. The federal government requires the NRC and agreement states to implement increased controls over certain types of radioactive material possessed in large quantities. Approximately 240 of approximately 1950 licensees in Texas possess such material and must establish procedures to minimize the likelihood that the radioactive material could be stolen or accessed for malevolent purposes.

**2001** – The Legislature establishes the Radiation and Perpetual Care Account to replace the Radiation Perpetual Care Fund to ensure funding for decontamination, decommissioning, stabilization, reclamation, maintenance, surveillance, control, storage, and disposal of radioactive materials in cases where a company cannot meet its legal obligation to restore the site.

**2003** – The Legislature requires the term of each license issued by DSHS to be two years and requires DSHS to charge licensing fees that would cover all necessary costs to administer and enforce the program.

**2004** – DSHS undergoes reorganization, creating functional units dedicated to inspections, enforcement, and licensing activities. The functional model improves availability of services to the regulated community and helps standardize quality assurance across programs.

**2007** – House Bill 2285 removes the requirement that the term of the licenses be tied to the two-year fee requirement. Senate Bill 1604 mandates transfer of the uranium and radioactive waste processing regulatory authority to the Texas Commission on Environmental Quality (TCEQ).

**2009** – House Bill 449 creates a regulatory program for laser hair removal. The legislation requires licensing of laser hair removal facilities and certification of individuals performing laser hair removal procedures.

**2013** – Senate Bill 347 establishes a new $100 million cap for the Perpetual Care Account and Environmental Radiation and Perpetual Care Account. The bill requires DSHS to use assessed fees for emergency planning and response to transportation accidents involving low-level radioactive waste; however, no appropriation is made.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

Radiation Control impacts companies that use radioactive materials, medical x-ray, and laser procedures; and individuals that receive diagnostic or therapeutic x-ray or laser procedures. Radiation Control also impacts users of lasers for entertainment, and facilities and individuals who perform laser hair removal. Radiation Control training affects first responders to radiological accidents and members of the public living near one of the foregoing operations.

| Number of Licenses, Registrant, and Mammography Certification<br>Fiscal Year 2012 | | |
|---|---|---|
| **Type of License/Certification** | **Number of Licenses** | **Number of Locations** |
| Radioactive Material Licensees | 1,606 | 2,267 |
| General Licenses | 273 | 392 |
| X-Ray Registrants | 16,717 | 19,829 |
| Laser Registrants | 1,979 | 2,241 |
| Mammography Certifications | 686 | 686 |
| Laser Hair Individual Certifications | 1,072 | N/A |
| Laser Hair Removal Facilities | 81 | N/A |
| Laser Hair Removal Training Providers | 13 | N/A |
| Industrial Radiographer Certifications | 3,831 | N/A |

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

RSD administers Radiation Control. The Regulatory Licensing Unit, Radiation Safety Licensing Branch conducts licensing and registration activities. Radioactive material licensing processes must be compatible with those of the NRC; the mammography certification and accreditation process must be compatible with the FDA requirements. DSHS performs x-ray registration activities in accordance with policies and regulation requirements. Staff reviews applications to confirm satisfaction of regulatory requirements in order to assure the safe use of these sources of radiation. This includes registration of laser hair removal facilities and certification of individuals who perform laser- hair removal procedures. Staff also conducts incident and complaint investigations. DSHS staff prepares examinations for individual industrial radiographers; administers and grades them; provides exam results to the individuals as

required by 25 Texas Administrative Code, Section 298.225; and provides successful applicants a certification identification card. A number of other states also use the tests through a contract between DSHS and the Conference of Radiation Control Program Directors.

The Environmental and Consumer Safety Section, Radiation Policy/Standards/Quality Assurance (PSQA) Group coordinates rules development with input from the radiation licensing, inspection, and other program staff. The PSQA Group also coordinates stakeholder participation in the rulemaking process. The group develops radiation standards based on health and safety considerations and compatibility with national standards developed by state and federal cooperative task forces for the multiple disciplines regulated. The PSQA Group also performs technical quality assurance reviews of inspection and investigation reports. The PSQA Group receives and reviews all associated paperwork, such as checklists, sample results, and report narratives, according to established standards in order to verify technical accuracy and completeness. The PSQA Group issues findings of inspections and investigations, including violations, based upon the inspection and investigation reports received. The PSQA Group prepares and presents cases that involve violations warranting enforcement to the Enforcement Unit.

The Environmental and Consumer Safety Section, Radiation Inspection Branch performs inspections of the licensees and registrants to assure that the sources of radiation are received, stored, used, and disposed of in accordance with the rules and permit requirements. The branch bases inspection frequency for each category of use on the risk posed by the source of radiation authorized and the past compliance record on the users. The branch conducts investigations of radiation accidents, incidents, and complaints and performs environmental monitoring around major radioactive material licensee facilities to assure that any releases of radioactive material to the environment are below release limits in the radiation rules. The branch also prepares and updates the state emergency response plans for response to accidents at nuclear facilities and conducts annual exercises at these facilities to assure that the plans, staffing, and resources are adequate. In addition, the branch provides radiological emergency response training and detection equipment along the Interstate 20 corridor and in the counties surrounding the fixed nuclear facilities.

In the Inspection Unit, the group managers, under the direction of the manager of the Radiation Inspection Branch, ensure that staff administers the inspection program consistently, and in accordance with agency and program policies. Group managers report the inspection activities to the PSQA Group where specialists review the findings of each inspection to determine if enforcement action is warranted; if warranted, the specialists refer the case to the Enforcement Unit.

The Enforcement Unit, with support from the Office of General Counsel, escalates enforcement actions and handles the due process requirements associated with prosecuting cases.

Radiation Control performs the regulatory functions for all areas of the state and is not involved with local health departments other than to provide expertise to them on an as-needed basis.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/regulatory.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $439,610 |
| General Revenue | $6,586,745 |
| General Revenue-Dedicated | $723,216 |
| Other | $66,034 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| TCEQ | DSHS regulates all users of radioactive material, but not the final disposal of low-level radioactive waste or uranium mining facilities. | TCEQ is responsible for regulating the disposal of low-level radioactive waste, all uranium mining including the underground portion of *in situ* uranium mining (Underground Injection Control Program), and the disposal of non-oil and gas Natural Occurring Radioactive Material (NORM). |
| Texas Railroad Commission (RRC) | DSHS regulates the use of NORM and decommissioning of facilities and sites with NORM contamination. | RRC is responsible for regulating the surface exploration for uranium ore and the disposal of oil and gas NORM. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

DSHS and TCEQ have a memorandum of understanding (MOU), as required by Section 401.414, Texas Health and Safety Code, to clarify their respective jurisdictions under the statute. The agencies are currently revising this MOU with a tentative completion date of June 2014. DSHS and RRC have a MOU, as required by Section 401.414, Texas Health and Safety Code, to clarify their respective jurisdictions under the statute. This MOU became effective January 2, 2012.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| County and local officials | County and local officials are involved with emergency response to nuclear reactor accidents and radiological emergency preparedness to radiological incidents in their areas. | DSHS Radiation Control technical experts advise the county judges and other local officials on emergency actions necessary to protect public health during routine graded exercises and in the event of a real emergency. DSHS also consults with and provides limited services to county judges and local emergency management officials regarding radiological plans, training, and instrumentation used to protect public health during radiation accidents and other emergencies. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| NRC | NRC has authority over radioactive materials but may delegate certain authority to states. | Texas is an agreement state with NRC. NRC provides regulatory guidance and policy concerning radioactive materials regulation and oversees the state's adequacy and compatibility with federal requirements. |
| FDA | FDA enforces the federal Mammography Quality Standards Act. | DSHS performs mammography certifications, accreditations, and inspections as a Certifying Agency under FDA, Mammography Quality Standards Act States as Certifiers provision. FDA approved the State of Texas Mammography Accreditation Program as an accreditation body. |

| Name | Description | Relationship to DSHS |
|---|---|---|
| Environmental Protection Agency (EPA) | EPA provides standards of human exposure to radiation. | EPA coordinates environmental monitoring for radioactive materials with DSHS and develops environmental radiation standards for environmental release limits and occupational radiation exposure standards. |
| FEMA | FEMA develops requirements for emergency response to nuclear facility accidents. The Radiological Emergency Preparedness Program provides FEMA approved radiological training. | FEMA grades full-scale exercises conducted by the state, county, and local government staff at the state's two nuclear utility facilities. DSHS staff provides recommendations to local and county officials after evaluating the radiological releases during exercises or in actual events. FEMA provides standards, goals, and objectives for radiological training. |
| DOE | DOE provides standards, goals, objectives, and audits for radiological training. | DSHS provides DOE-approved radiological training to first responders along the Interstate 20 corridor. DOE also funds DSHS emergency response activities for the Pantex nuclear weapons production facility near Amarillo. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The program does not have any contracts.

**L. Provide information on any grants awarded by the program.**

The program does not award grants.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

Industrial, educational, and medical facilities make use of radioactive material and x-ray machines for the benefit of Texas citizens. Examples of the beneficial uses of radiation include diagnostic nuclear medicine studies, emergency exit lighting, nondestructive testing of critical components in passenger aircraft, pipeline radiography, sterilization of surgical bandages, treatment of cancer, and highway construction materials testing. Regulatory oversight of these uses of radioactive materials and x-ray machines ensures continuation of the beneficial uses and minimizes unnecessary radiation exposure to occupational workers and the public in Texas.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

DSHS is the lead agency for all radioactive material, mammography certification, x-ray, and laser regulatory and safety efforts in the state to protect workers, the public, and the environment. Radiation Control protects the public health and safety with regulation permitting requirements and routine inspections that result in improved compliance, less unnecessary exposure to sources of radiation, and secure sources of radioactive material.

In order to allocate resources for maximum benefit to public health and consumer safety, Radiation Control bases inspection activities on a risk assessment of the potential harm from each category of sources of radiation. Radiation Control uses a standardized inspection methodology when conducting inspections. Inspection methodology includes standard forms, checklists, and attachments necessary to document the findings of each type of inspection. Radiation Control reinforces standard inspection methodology with initial and recurring training for all inspectors to ensure that staff conducts inspections consistently across the state. The PSQA Unit provides training and oversight of inspection documentation with audits, as necessary, to assess the quality standards.

Paralleling the growth in industry and medicine in Texas, the use of radiation has increased significantly. Industrial, medical, and educational facilities in Texas use radiation sources. Additionally, the state has two nuclear utility facilities. Excessive exposure to radiation presents a public and occupational health hazard. Radiation is a known carcinogen. Currently, no federal program exists to protect the public from impacts associated with all types and origins of radiation exposure.

Procedures for inspection of licensee and registrant performance include observation of operations, review of documentation, surveys of radiation levels, and evaluation of radiation exposures. Inspections that reveal violations of regulatory requirements result in the issuance of a notice of violation that requires corrective action to prevent reoccurrence. Radiation Control staff reviews corrective actions during the following inspection. Sanctions of violators that are available include administrative penalties, emergency orders (cease and desist, impoundment), and modification/revocation of licenses.

Radiation Control also conducts activities as the lead agency for radiological emergency response for the state and responds to any nuclear reactor accident or radiological terrorist threat.

Radiation Control receives complaints in writing or by telephone and investigates all complaints based on program guidelines or administrative review. The primary emphasis of an investigation is to assure that health and safety issues are resolved. After complaints are resolved and closed, Radiation Control files the information collected, reports of actions taken, and makes the information available as open records.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

**Department of State Health Services**
**Radiation Control**
**Exhibit 11: Information on Complaints Against Regulated Persons or Entities**
**Fiscal Years 2011 and 2012**

| | FY 2011 | FY 2012 |
|---|---|---|
| Total number of regulated entities | 25,105 | 26,258 |
| Total number of entities inspected | 5,879 | 7,932 |
| Total number of complaints received from the public | 59 | 69 |
| Total number of complaints initiated by agency | 74 | 72 |
| Number of complaints pending from prior years* | 11 | 9 |
| Number of complaints found to be non-jurisdictional | 1 | 1 |
| Number of jurisdictional complaints found to be without merit | 55 | 40 |

| Department of State Health Services<br>Radiation Control<br>Exhibit 11: Information on Complaints Against Regulated Persons or Entities<br>Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| Number of complaints resolved | 73 | 72 |
| Average number of days for complaint resolution | 53 | 56 |
| Complaints/inspections resulting in disciplinary action:** | | |
| administrative penalty | 43 | 63 |
| reprimand | N/A | N/A |
| probation | 6 | 1 |
| suspension | 1 | 2 |
| revocation | 72 | 49 |
| other | 0 | 11 |
| Number of environmental samples collected*** | 639 (1,968) | 619 (2,024) |

* Some complaints from the previous year were resolved during the timeframe given.

** Because staff takes the majority of disciplinary actions as the result of routine inspections, reporting only disciplinary actions taken as a result of complaints would provide an inaccurate picture of the total disciplinary actions taken. These numbers also include enforcement actions resulting from referrals from licensing (e.g., fee delinquencies).

*** The number in parenthesis includes environmental radiation monitors.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Healthcare Professionals |
| **Location/Division** | 8407 Wall Street, Austin - Regulatory Services Division (RSD) |
| **Contact Name** | Kathryn C. Perkins, Assistant Commissioner, RSD |
| **Actual Expenditures, FY 2012** | $6,876,437 |
| **Number of Actual FTEs as of June 1, 2013** | 116.2 |
| **Statutory Citation for Program** | Chapters 12 (Subchapter H), 773, and 781, Texas Health and Safety Code; Chapters 110, 203, 352, 353, 401-403, 451, 455, 502, 503-505, 601-605, 701, 1952, and 1953, Texas Occupations Code; Sections 521.371 – 521.377, Texas Transportation Code; Article 42.12, Sections 13(h) and 13(j), Texas Code of Criminal Procedure; Section 106.115, Alcoholic Beverage Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Healthcare Professionals has the primary objective to issue licenses, certifications, and other registrations of healthcare professionals, and to ensure compliance with standards.

**Regulatory Programs and Activities with Governor-Appointed Boards with Independent Rulemaking Authority**

The following healthcare professionals have boards with independent rulemaking authority:

- athletic trainers,
- audiologists, counselors, dietitians, fitters and dispensers of hearing instruments,*
- marriage and family therapists,
- medical physicists,*
- midwives and associated training programs (Board is appointed by DSHS Commissioner and has rulemaking authority),*
- orthotists and prosthetists and associated facilities,
- sex offender treatment providers,
- social workers, and
- speech-language pathologists.

*These three boards have quasi-independent rulemaking authority, in that their final rules require approval by the HHSC Executive Commissioner for adoption.

**Regulatory Programs and Activities that do not have Governor-Appointed Boards with Independent Rulemaking Authority**

The following healthcare professionals do not have boards with independent rulemaking authority:

- chemical dependency counselors and associated training entities,
- code enforcement officers,
- contact lens dispensers,
- dyslexia practitioners and therapists,
- emergency medical services personnel and associated firms,
- massage therapists and associated establishments and training programs,
- medical radiologic technologists and associated training programs,
- offender education programs and instructors,
- opticians,
- perfusionists,
- personal emergency response system providers,
- respiratory care practitioners, and
- sanitarians.

For regulation of all the healthcare professions and programs listed above, DSHS evaluates credentials and qualifications; administers or recognizes examination requirements; processes initial and renewal applications for licensure, permitting, certification, and specialty recognition; and issues and renews licenses, permits, and certifications. DSHS staff also provides intake and processing for consumer complaints, investigates the complaints, and determines proposed violations and sanctions. Healthcare Professionals establishes program policy, procedure, and standards for the regulation of these healthcare professions; handles stakeholder relations; provides public information and education; develops curriculum; and provides training.

For independent rulemaking boards, Healthcare Professionals coordinates the rulemaking activities and handles board and committee relations and support. For healthcare professions governed by these boards, Healthcare Professionals also issues notices of violation and holds enforcement/settlement conferences.

For regulation of healthcare professions without independent rulemaking, Healthcare Professionals coordinates and initiates rulemaking by the HHSC Executive Commissioner. Additionally, Healthcare Professionals coordinates the enforcement review committee to determine violations and sanctions, issues notices of violation, coordinates informal conferences and hearings, and issues final orders.

**Medical Review for Driver Licensing and Concealed Handgun Licensing**
DSHS staff reviews referrals from the Texas Department of Public Safety (DPS) that relate to driver's license applicants and concealed handgun license applicants, renders an opinion regarding whether a person is capable of safely operating a motor vehicle or is capable of exercising sound judgment with respect to proper use and storage of a handgun, and makes recommendations to DPS. Effective September 1, 2013, this will include referrals that relate to applicants for private security commissions. The DSHS Commissioner appoints Medical Advisory Board members, all of whom by law must be physicians and optometrists.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

Continuous improvement, resulting in more efficient and effective customer and licensing service, is a management priority for Healthcare Professionals. Improvement and quality assurance activities include the following.

- Since October 2002, the Professional Licensing and Certification (PLC) Unit surveys license holders biennially to assess the level of satisfaction with the license renewal process, the ability of the program staff to communicate effectively and courteously, the quality of program written materials, and the quality of the program websites. The PLC Unit uses the survey information as a basis for improving the license renewal process, staff training, and public information. The unit maintains the data by unit, by program, by question, and by time period. For example, survey respondents from the professional counselor licensing program reported an overall satisfaction rate of 93.4 percent in fiscal year 2012.
- The PLC Unit regularly monitors telephone call volume and service to ensure quality. RSD has divided the PLC Unit into five customer service groups for purposes of receiving phone calls. The unit tracks the average length of call, number of calls transferred, and average wait time both in real time and cumulatively, and implements staffing adjustments as necessary. During fiscal year 2012, the PLC Unit received 19,560 calls (approximately 1630 per month).
- In 2006, DSHS implemented a consolidated licensing database system within the PLC Unit (Project Phase I). The system, License Ease, integrates licensing, inspection, and enforcement functions for the programs. Implementation of the system was the culmination of an information technology (IT) project involving DSHS IT staff and contracted staff from Versa, Inc. The project included a majority of the programs within the RSD. Implementation activities included business planning, configuration, data migration, and staff training. A number of obsolete systems were retired upon the successful implementation of the system.
- In 2010, the consolidated system, License Ease, migrated to Versa Regulation. In 2011, the first professional licensing renewal transactions occurred through Versa Online.
- The PLC Unit regularly assesses components of individual programs to ensure that processes and requirements are both reasonable and streamlined to the extent possible. For

example, DSHS revised the Drug Offender Education Program curriculum after a study of best practices.

- Healthcare Professionals staff regularly assesses information relating to the programs to ensure that it remains current, accurate, and useful to consumers and license holders. DSHS redesigned program websites in 2005 to meet Health and Human Services System standards and to improve the consistency and availability of information regarding the programs. Boards, committees, and staff regularly review and update consumer brochures and other information.
- DSHS has fully implemented statutory modifications and management recommendations from the 2005 Sunset Advisory Commission reviews of six boards within the PLC Unit, including jurisprudence examinations for new licensure applicants.
- DSHS has fully implemented statutory modifications and management recommendations from the 2011 Sunset Advisory Commission reviews of two boards within the PLC Unit, including criminal history fingerprinting requirements for new and renewal applicants.
- The PLC Unit conducts rule reviews in accordance with the Administrative Procedure Act to ensure that rules reflect current policy, legal, and programmatic considerations. As required by law, the program conducts reviews of the 23 sets of rules every four years.
- In 2005, four programs in the PLC Unit established and implemented ongoing continuing education provider audits. These audits ensure that approved continuing education providers are providing quality education in compliance with program rules.
- In 2006, the State Auditor's Office conducted a review of the use of criminal history background information within three programs in the PLC Unit. While there were no significant adverse findings, the programs successfully implemented the resulting management recommendations by increasing the use of risk-based criminal history checks.

Continuous improvement and appropriate targeting of resources in investigations and inspections are ongoing activities. The PLC Unit prioritizes complaints by severity level, and conducts investigations in a manner that optimizes the use of travel funds and staff resources.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1997** – The Legislature adds a level of regulation, licensed paramedic, to the emergency medical services (EMS) area. In addition to other standards, a licensed paramedic must hold a post-secondary degree. Other levels of EMS certification include emergency care attendant, emergency medical technician (EMT) basic, and EMT intermediate.

**2001** – The Legislature creates the Governor's EMS and Trauma Advisory Council (GETAC) to advise the legacy Texas Department of Health (TDH) on rules regarding EMS and trauma systems. GETAC serves as a gathering point for stakeholder input on rules regarding the licensing, certification, and enforcement of EMS personnel and entities.

**2003** – Healthcare Professionals begins the process of reorganizing along functional lines as a means to improve overall program functioning, provide greater flexibility to meet current and anticipated future workload demands, increase staff knowledge and expertise, and realize efficiencies in the use of program resources.

**2004** – Healthcare Professionals completes a formal project to make licensing services available through the Texas Online portal. Online services currently include application for licensure, renewal of licensure, and change of address. Additionally, the regulation of offender education programs and chemical dependency counselors, formerly at the legacy Texas Commission on Alcohol and Drug Abuse, merged with Healthcare Professionals at DSHS.

**2005** – The Legislature creates a subcommittee of GETAC on stroke systems. Additionally, H.B. 1126 prohibits DSHS from licensing gurney cars as a type of ambulance. Gurney cars are vehicles that have no medical equipment nor medically trained personnel. These types of vehicles are appropriate for non-emergency transfer of ambulatory persons or those using a wheelchair but may compromise the safety of patients who are so ill as to require transport by stretcher.

**2006** – Healthcare Professionals completes the change from one-year to two-year licensing, as mandated by legislation in 2003. This requirement does not apply to all licensing programs; for example, the EMS personnel certification period is four years. Healthcare Professionals also participates in a formal project to consolidate licensing database software and implement a common licensing database system.

**2008** – DSHS completes a four-year criminal history check review of all EMS-certified licensees.

**2009** – The Legislature establishes a bar or mandatory revocation of an EMS license or certification for persons convicted or placed on a deferred community supervision for certain crimes, including a person that had to register as a sex offender after September 1, 2009. Additionally, H.B. 461 creates the licensing program for dyslexia practitioners and dyslexia therapists, as well as the Dyslexia Licensing Advisory Committee.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

Healthcare Professionals directly affects allied health, mental health, and emergency medical services professionals and providers, as well as consumers of those services in Texas. The functions of the Medical Advisory Board (MAB) protects citizens from the risks posed by persons who have conditions that render them incapable of operating a motor vehicle safely or of properly storing and using a handgun.

Each regulatory program's enabling statute and associated rules establish qualifications and eligibility requirements for persons seeking to practice in the regulated profession or occupation. The requirements may include a range of educational, experience, and examination requirements, in addition to a review of a person's criminal history to determine fitness for licensure.

There are approximately 225,000 persons and entities regulated through Healthcare Professionals.

| Profession | Total Regulated Population FY 2012 |
|---|---|
| Athletic trainers | 2,868 |
| Audiologists | 1,205 |
| Chemical dependency counselors and associated training entities | 8,961 |
| Code enforcement officers | 2,206 |
| Contact lens dispensers | 176 |
| Emergency medical services personnel | 63,833 |
| Emergency medical services firms and first responder organizations | 1,802 |
| Emergency medical services education programs | 517 |
| Counselors, professional | 19,435 |
| Dietitians | 4,828 |
| Dyslexia therapists and practitioners | 973 |
| Fitters and dispensers of hearing instruments | 754 |
| Marriage and family therapists | 3,291 |
| Massage therapists and associated establishments and training programs | 29,596 |
| Medical physicists | 614 |
| Medical radiologic technologists and associated training programs | 27,844 |
| Midwives and associated training programs | 219 |
| Offender education programs and instructors | 2555 |
| Opticians | 129 |
| Orthotists and prosthetists and associated facilities | 837 |
| Perfusionists | 366 |
| Personal emergency response system providers | 249 |
| Respiratory care practitioners | 14,230 |
| Sex offender treatment providers | 498 |
| Social workers | 22,066 |
| Speech-language pathologists | 15,465 |
| Sanitarians | 1,241 |

The MAB receives approximately 5,700 referrals annually from DPS in accordance with Section 12.092(b), Texas Health and Safety Code. DPS requests assistance in determining whether an applicant for a driver's license or a license holder is capable of safely operating a motor vehicle, or whether an applicant for or holder of a license to carry a concealed handgun is capable of exercising sound judgment with respect to the proper use and storage of a handgun. A DPS referral is the only qualification or eligibility requirement for review by the MAB. A license applicant referred by DPS is required to supply medical records and information necessary for the MAB to render an opinion regarding the person.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

Five units within RSD administer Healthcare Professions. The division divides each unit into groups with specialized licensing, policy, education, standards, or enforcement functions. The PLC Unit houses licensing, policy, education, and quality assurance functions for 22 mental health, allied health, and health-related professions, as well as offender education programs. The Regulatory Licensing Unit houses the Board and the licensing functions related to EMS, as well as other licensing functions that are not part of this program. The Patient Quality Care Unit houses compliance and quality assurance for EMS licensing, as well as other functions not included within this program. The Enforcement Unit has responsibility for all enforcement functions within RSD, including Healthcare Professionals. The EMS/Trauma Systems Coordination Office houses policy and education functions for EMS licensing, as well as other EMS and trauma-related functions in the EMS/Trauma Program. DSHS licenses the ambulance services according to their designated capability levels under Healthcare Professionals. RSD combines investigations against EMS personnel with the investigations against EMS providers, plus EMS provider surveys and inspections. Healthcare Facilities performs these investigations.

A unique administrative feature within the PLC Unit is the presence of 11 licensing boards with independent rulemaking and enforcement authority. The Governor appoints members to 10 of the boards. These regulatory boards are statutorily mandated and are administratively attached to DSHS. DSHS provides staff, facilities, and infrastructure necessary to accomplish the mission and functions of each board. PLC program specialists serve as executive directors for the boards and coordinate meetings, rulemaking, stakeholder relations, and enforcement actions.

The functions of Healthcare Professionals are primarily in the DSHS central office in Austin. EMS has a central office with statewide oversight over the licensing, compliance, and enforcement regulatory functions. Four zone compliance offices (Central, North, East, and South) are located in DSHS regional offices for compliance field staff. A close relationship exists between the regulation of the providers and the personnel, which enhances regulatory effectiveness and efficiency across the state.

The Council on Sex Offender Treatment (CSOT) is a Governor-appointed council that has been administratively attached to the PLC Unit since 1997. In 1983, the 68th Legislature created the CSOT due to the rising rate of sexual crimes and extremely high recidivism rates for untreated sexual offenders. Over the past two decades, CSOT's core function as a regulatory entity has expanded due to the increased public awareness and concern for community safety. Today, CSOT has three primary functions, as described by Chapter 110, Texas Occupations Code:

- public and behavioral health by advocating for the management and treatment of sex offenders;
- regulatory by administering a licensure program for sex offender treatment providers, establishing the rules and regulations regarding the treatment of sex offenders, and maintaining a list of sex offender treatment providers; and
- educational by the dissemination of information to the public regarding the treatment and management of sex offenders.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/regulatory.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $815,380 |
| General Revenue | $3,418,958 |
| General Revenue-Dedicated | $1,500,819 |
| Other | $1,141,280 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

No other state government programs, internal or external, engage in the specific regulation authorized by the enabling statutes for Professionals. Other state programs and agencies regulate professions and occupations, but not the specific occupations that this program regulates.

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

Not applicable.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Local school districts | Local school districts may employ athletic trainers that DSHS regulates. | The Athletic Trainer Licensing Program interacts regularly with school districts throughout the state to disseminate information regarding licensure and enforcement actions. |
| Local law enforcement | Local law enforcement agencies enforce the laws in their jurisdictions. Licensed healthcare professionals may be the subject of law enforcement investigations. | Healthcare Professionals cooperates, as appropriate, with local investigations into allegations against license holders and may propose enforcement action either in conjunction with other agencies or in response to information received from other agencies or units of government. |
| Local city and county governments | Local city and county governments operate EMS and may have local EMS ordinances. | The EMS Program coordinates with local city and county governments regarding EMS regulation, especially if the local unit has an EMS ordinance. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The program does not have any contracts.

**L. Provide information on any grants awarded by the program.**

The program does not award any grants.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory change to assist the program in performing its functions.

**Chapter 773, Texas Health and Safety Code** – DSHS recommends a revision to this statute to:

- provide authority to assess an administrative penalty against individuals;
- create two categories of provider licensure: one license for non-emergency medical transport providers and another license for 911 emergency providers;
- provide increased authority to assess an administrative penalty for licenses up to $10,000 per day per violation;
- add EMS initial education and continuing education programs to the type of licenses for which DSHS can assess an administrative penalty;
- clarify that DSHS has authority to regulate licensed and unlicensed activity; and
- provide ambulance detention authority to DSHS.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

Eight of the eleven Governor-appointed licensing boards that Healthcare Professionals provides administrative support have separate Sunset review dates in their enabling statutes. The three boards that do not have separate Sunset review dates are the CSOT, Advisory Board of Athletic Trainers, and the Texas Board of Licensure for Professional Medical Physicists.

During the 1992-1993 review cycle, the Sunset Advisory Commission reviewed seven boards (speech-language pathologist and audiologist, marriage and family therapist, professional counselor, dietitian, social worker, midwifery, and hearing aid fitter and dispenser). As a result of the review, the Texas Legislature abolished the Texas Board of Examiners in the Fitting and Dispensing of Hearing Aids as an independent state agency and replaced it with an independent board administratively attached to the RSD. The Legislature continued the other boards for an additional 12 years with certain modifications to their enabling statutes.

In 1997, the 75th Legislature placed the CSOT within the legacy TDH as a result of a Sunset Advisory Commission review. The CSOT was formerly an independent state agency.

During the 2004-2005 review cycle, the Sunset Advisory Commission reviewed six boards (marriage and family therapist, professional counselor, midwifery, perfusionist, dietitian, and social worker). The Legislature abolished the perfusionist board and replaced it with an advisory committee. The Legislature continued the other five boards for an additional 12 years with certain modifications to their enabling statutes.
During the 2010-2011 review cycle, the Sunset Advisory Commission reviewed two boards (fitter and dispenser of hearing instruments, and speech-language pathologist and audiologist). The Legislature continued the boards until 2017 with certain modifications to their enabling statutes.

During the 2016-2017 review cycle, the Sunset Advisory Commission is scheduled to review the following nine boards and programs: marriage and family therapist, professional counselor, midwifery, perfusionist, dietitian, social worker, fitter and dispenser of hearing instruments, orthotics and prosthetics, and speech-language pathologist and audiologist.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

The regulation of allied health, mental health, and emergency medical occupations is a means to protect and promote public health, safety, and welfare. The regulation helps ensure that consumers are availing themselves of the services of qualified and competent providers.

Most of Healthcare Professionals license holders are individuals who are not subject to inspection, but are subject to audit processes regarding continuing education compliance. They are subject, however, to investigation when consumers or agency staff files allegations of wrongdoing. Healthcare Professionals staff verifies suspected violations of law or rule through an investigation and presents the results to the Enforcement Review Committee (or the appropriate committee of an independent board) for consideration and imposition of proposed disciplinary action, if appropriate.

License holders selected for continuing education audit are subject to Texas criminal history background checks, except those license holders who have undergone fingerprint-based criminal history checks. DSHS also performs these checks on all new licensure applicants.

When the agency identifies non-compliance, DSHS may take a number of follow-up actions. In an enforcement matter, DSHS may require the license holder to complete additional education

in addition to enforcement sanctions, such as probation or suspension. In some enforcement matters, the regulatory authority may require another license holder to supervise reporting requirements. Program staff monitors these enforcement orders for compliance. If Healthcare Professionals receives another complaint, or if the problem appears to be unresolved, DSHS can re-investigate and refer to the appropriate committee for review.
The Legislature has authorized DSHS and the independent boards attached to DSHS to impose a broad range of enforcement sanctions to ensure compliance with the enabling statutes and rules. These sanctions vary somewhat by program, but generally include application or renewal application denial, administrative penalties, emergency suspension, reprimand, suspension, probation, or revocation. Additionally, DSHS and independent boards may use agreed orders, requirements for additional education, practice limitations, and/or other appropriate measures to resolve contested cases.

DSHS may conduct inspections and audits of facilities and business entities regulated through Healthcare Professionals if authorized by statute and/or upon receipt of a jurisdictional consumer complaint. The scope of inspections is set out in the applicable statute or rules.

DSHS audits EMS personnel for compliance with certification and licensing standards. This includes continuing education compliance as well as in-depth criminal history evaluations. Beginning in September 2004, the EMS Program implemented a 100 percent criminal history review of all initial and renewal certificates; DSHS staff evaluates applicants' criminal history through DPS. On January 1, 2010, DSHS began requiring a fingerprint-based criminal background check for all EMS initial applicants, which is a state and federal check for criminal activity. This was a result of legislation that passed in 2009 establishing a bar or mandatory revocation of an EMS license or certification for persons convicted or placed on a deferred community supervision for certain crimes, including a person that had to register as a sex offender after September 1, 2009.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

**Department of State Health Services**
**Healthcare Professionals**
**Professional Licensing and Certification Unit**
**Exhibit 11: Information on Complaints Against Regulated Persons or Entities**
**Fiscal Years 2011 and 2012**

| | FY 2011 | FY 2012 |
|---|---|---|
| Total number of regulated persons | 152,520 | 157,986 |
| Total number of regulated entities | 2,615 | 2,620 |
| Total number of entities inspected | 420 | 453 |
| Total number of complaints received from the public | 1309 | 1,194 |
| Total number of complaints initiated by agency* | N/A | N/A |

| Department of State Health Services<br>Healthcare Professionals<br>Professional Licensing and Certification Unit<br>Exhibit 11: Information on Complaints Against Regulated Persons or Entities<br>Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| Number of complaints pending from prior years | N/A | N/A |
| Number of complaints found to be non-jurisdictional | 83 | 81 |
| Number of jurisdictional complaints found to be without merit | 330 | 280 |
| Number of jurisdictional complaints resolved | 1,051 | 994 |
| Average number of days for complaint resolution | 265 | 263 |
| Complaints resulting in disciplinary action: | | |
| administrative penalty | 50 | 58 |
| reprimand | 38 | 15 |
| probation | 51 | 38 |
| suspension | 10 | 28 |
| revocation | 33 | 14 |
| other (letters of warning, cease and desist letters, denials, and surrenders) | 480 | 489 |

* DSHS staff enters all complaints, regardless of source, into a consolidated database. Staff estimates that DSHS initiates no more than 10 percent of complaints.

| Department of State Health Services<br>Healthcare Professionals<br>EMS Providers*<br>Exhibit 11: Information on Complaints Against Regulated Persons or Entities<br>Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| Total number of regulated persons | 65,287 | 66,133 |
| Total number of regulated entities (providers, education programs, and first responder programs) | 2,232 | 2,319 |
| Total number of entities inspected (complaint investigations) | 2,046 | 1,954 |
| Total number of complaints received from the public | 71 | 64 |
| Total number of complaints initiated by agency | 187 | 493 |
| Number of complaints pending from prior years | 312 | 515 |
| Number of complaints found to be non-jurisdictional | 0 | 2 |
| Number of jurisdictional complaints found to be without merit** | N/A | N/A |
| Number of complaints resolved*** | 246 | 202 |
| Average number of days for complaint resolution | 91 | 65 |
| Complaints resulting in disciplinary action: | | |

| Department of State Health Services<br>Healthcare Professionals<br>EMS Providers*<br>Exhibit 11: Information on Complaints Against Regulated Persons or Entities<br>Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| administrative penalty | 85 | 173 |
| reprimand | 69 | 112 |
| probation | 8 | 11 |
| suspension | 41 | 35 |
| revocation | 47 | 75 |
| other | 16 | 17 |

Numbers are based on state performance measure reports.

* These numbers include complaint investigations against both EMS providers and EMS personnel.

** N/A=information in this category is not collected by database in this manner.

*** Resolved=investigation completed and case referred to Enforcement Review Committee.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Healthcare Facilities |
| **Location/Division** | 8407 Wall Street, Austin - Regulatory Services Division (RSD) |
| **Contact Name** | Kathryn C. Perkins, Assistant Commissioner, RSD |
| **Actual Expenditures, FY 2012** | $9,351,689 |
| **Number of Actual FTEs as of June 1, 2013** | 114.6 |
| **Statutory Citation for Program** | Chapters 222, 241, 243, 244, 245, 248, 251, 254, 464, 466, and 577, Texas Health and Safety Code; Chapter 74, Subchapter C, Civil Practice and Remedies Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Healthcare Facilities has the primary objective of implementing programs to license/certify non-long-term care facilities, monitor compliance, enforce rules/regulations, and provide technical assistance to healthcare facilities. Major activities include the following.

**Licensed Only Facilities (Abortion Facilities, Birthing Centers, Crisis Stabilization Units, Special Care Facilities, and Substance Abuse Treatment Facilities)**
Healthcare Facilities staff assists in the development and implementation of licensing rules, issues licenses, and conducts surveys and complaint investigations to determine compliance with state licensing rules and regulations, and cite applicable violations.

**Licensed and Medicare-Certified Facilities (Ambulatory Surgical Centers, End-Stage Renal Disease Facilities, Freestanding Emergency Medical Care Facilities, Hospitals-General and Special, and Hospitals-Psychiatric)**
Healthcare Facilities staff assists in the development and implementation of licensing rules, makes licensing decisions, and makes recommendations regarding certification of these facilities to the Centers for Medicare & Medicaid Services (CMS). When facilities are in compliance with Medicare Conditions of Participation, these providers are allowed to seek Medicare reimbursement for care provided to consumers. Healthcare Facilities staff performs surveys and complaint investigations to determine compliance with state and federal rules and regulations, and cites applicable violations.

**Medicare-Certified Only Facilities (Comprehensive Outpatient Rehabilitation Facilities, Clinical Laboratories, Outpatient Physical Therapy or Speech Pathology Services, Portable X-Ray Services, and Rural Health Clinics)**

Healthcare Facilities staff makes recommendations to CMS regarding the certification of these facilities. When they are determined to be in compliance with Medicare Conditions of Participation, these providers can seek Medicare reimbursement for care provided to consumers. Healthcare Facilities staff conducts surveys and complaint investigations of these facilities to determine compliance with state and federal regulations and cites applicable violations. Healthcare Facility staff assists in certifying community mental health centers, although staff does not survey the facilities.

Healthcare Facilities staff also supports the Texas Medical Disclosure Panel (TMDP), which is administratively attached to DSHS by statute. TMDP determines which risks and hazards related to medical care and surgical procedures healthcare providers or physicians must disclose to their patients and establishes the general form and substance of the disclosure. TMDP is composed of nine members appointed by the DSHS Commissioner. Six members must be licensed physicians and three members must be licensed attorneys.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

During fiscal year 2012, the Healthcare Facilities staff conducted 1,737 complaint investigations and 3,655 surveys/inspections, and issued 3,774 initial and renewal licenses. Staff determined that approximately 94 percent of all healthcare facilities complied with applicable statutes and rules at the time of their surveys/inspections.

DSHS is the designated state agency in Texas to conduct non-long-term care surveys [Medicare and Clinical Laboratory Improvement Amendments of 1988 (CLIA) Medicare surveys in Texas]. As part of the "Section 1864 Agreement" (Social Security Act, Section 1864) between Texas and the federal government, CMS requires DSHS to submit quarterly reports related to workload, full-time equivalents, staff training, and initial surveys. CMS provides a Mission and Priority Document as part of the annual process for requesting federal funding. DSHS then estimates the workload that staff can accomplish, based on the expected level of funding that CMS will provide. DSHS plans its workload and scheduling priorities, based on a mandated federal survey frequency for each provider type. The CMS Dallas regional office and DSHS are in frequent communication regarding the survey operations and workload activities.

CMS provides an annual evaluation related to survey activities called the State Performance Standards System (SPSS) Report. CMA conducts the evaluation for both the non-long-term care and the CLIA programs. This review focuses on three areas related to state agency performance of Medicare activities (frequency, quality, and enforcement). The CMS criteria pertains to the frequency of non-long-term care surveys, accuracy and frequency of data entry,

documentation of deficiencies, prioritizing complaints and incidents, timeliness of complaint and incident investigations, timeliness of immediate jeopardy actions, and adherence to the Conditions of Participation. The CLIA SPSS criteria are similar but relate specifically to laboratory surveys. CMS prepares a report for DSHS, identifying any unmet review criteria. After a discussion regarding findings, DSHS and CMS reach a final decision regarding the SPSS Report. DSHS must submit a plan of correction for any areas of operation that CMS identified as needing improvement. Staff training may occur as part of the corrective action plan.

The group managers in Healthcare Facilities perform limited quality assurance (QA) reviews of statements of deficiency, reports of contact, and various correspondence. In addition, QA staff has developed a surveyor procedure manual and a QA program for healthcare facility compliance activities. The QA program develops criteria for random sampling of survey documents to determine compliance with the CMS Principles of Documentation and the criteria established by the SPSS. After QA completes an analysis of survey documents, staff receives feedback and training, as needed. The goal is to improve the effectiveness and efficiency of compliance activities. The success of state and federal enforcement actions provide a form of QA for compliance activities as well.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**2003** – Senate Bill 1152 requires Healthcare Facilities to provide regulated entities the option of renewing licenses via Texas Online, the official e-government website. The Legislature also mandates that the term of each license issued by state agencies be two years. This requirement applies to licenses, permits, registrations, and certificates issued or renewed on or after January 1, 2005. The requirement applies to all activities within Healthcare Facilities.

Legislation that passes in 2003 also eliminates the Texas Commission on Alcohol and Drug Abuse, and the substance abuse treatment facilities program became part of DSHS.

**2009** – House Bill 1357 requires DSHS to regulate freestanding emergency medical care facilities. The rules for these facilities become effective June 1, 2010, and require facilities to be licensed by September 1, 2010.

**2013** – Several bills are enacted during the 83rd Legislature that affect health facilities: S.B. 793 relates to newborn screening requirements for hospitals and birthing centers; S.B. 944 relates to criminal history checks for certain hospital staff; S.B. 945 relates to hospital staff identification badges; S.B. 1191 relates to hospitals and sexual assault survivors and a website list of all hospitals identified in a community plan; and S.B. 1643 relates to certain controlled substances. Additionally, H.B. 705 relates to emergency services personnel and enhanced criminal penalty; H.B. 729 relates to access by facilities to certain criminal history; H.B. 740

relates to newborn screening in a hospital; and H.B. 1376 relates to hospital and freestanding emergency centers advertising their rates for services.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

In general, Healthcare Facilities regulation directly impacts any consumer who seeks healthcare services in Texas by ensuring that proper policies and procedures, equipment, facilities, and trained personnel are available to deliver care and services in a safe manner.

The licensed-only facilities are abortion facilities, birthing centers, crisis stabilization units, special care facilities, substance abuse treatment facilities, and freestanding emergency medical care facilities.

| Type of Facility | Number Licensed as of June 17, 2013 |
|---|---|
| Abortion Facilities | 36 |
| Birthing Centers | 61 |
| Crisis Stabilization Unit | 3 |
| Freestanding Emergency Medical Care Facilities | 64 |
| Special Care Facilities | 14 |
| Substance Abuse Treatment Facilities | 579 |

To operate in Texas, these facilities must have a license. To obtain a license, a facility must complete a multi-page license application properly, submit any required documentation, pay the required licensing fee, and pass an architectural/life safety code and health survey, if applicable. A license is valid for two years, with the exception of freestanding emergency medical care centers, which are licensed annually. For a facility to retain its license, it must demonstrate that it is in substantial compliance with the current state licensing laws and rules, based on the results of any survey, complaint, or incident investigation and follow-up visit.

The licensed and Medicare-certified facilities are ambulatory surgical centers, end-stage renal disease (ESRD) facilities, hospitals-general and special, and hospitals-psychiatric.

| Type of Facility | As of June 17, 2013 | |
|---|---|---|
| | Number of Licensed Facilities | Number of Medicare-Certified Facilities |
| Ambulatory Surgical Centers | 422 | 314 |
| End-Stage Renal Disease Facilities | 561 | 400 |
| Hospitals-General and Special | 647 | 535 |
| Hospitals-Psychiatric* | 38 | 38 |

* Six State Hospitals in Texas are not licensed but are Medicare-certified.

To operate in Texas, these facilities must have a license. To obtain a license, a facility must complete a multi-page license application properly, pay the required licensing fee, and pass an architectural/life safety code and health survey, if applicable. A license is valid for two years.

A provider's participation in the federal Medicare program is voluntary. Each facility must have certification for the appropriate Medicare program in order to serve clients who are eligible for this program. Once DSHS finds the facility in compliance with state and federal regulations, DSHS recommends to CMS that the facility be certified. For a facility to retain its license and certification, the results of any survey, complaint, or incident investigation and follow-up visit must indicate that the facility is in substantial compliance with the current state and federal laws and rules.

The Medicare-certified only facilities are comprehensive outpatient rehabilitation facilities, clinical laboratories, outpatient physical therapy or speech pathology services, portable x-ray services, and rural health clinics.

| Type of Facility | Number Licensed as July 17, 2013 |
|---|---|
| Comprehensive Outpatient Rehabilitation Facilities | 67 |
| Clinical Laboratories | 20,461 |
| Outpatient Physical Therapy or Speech Pathology Services | 230 |
| Portable X-ray Services | 42 |
| Rural Health Clinics | 322 |

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The Regulatory Licensing Unit, Healthcare Facility Group handles all licensing functions. The Patient Quality Care Unit, which is comprised of six Health Facility Compliance Groups across the state, conducts all compliance functions (state and federal). The Enforcement Unit, Consumer Safety Group handles all healthcare facility enforcement functions.

Healthcare Facilities staff conducts surveys and complaint investigations of healthcare facilities that are State-licensed only. Pursuant to the Section 1864 Agreement between the U.S. Department of Health and Human Services (DHHS) and Texas, two state agencies have responsibility for licensing healthcare facilities. The Texas Department of Aging and Disability Services (DADS) regulates long-term care facilities such as assisted living facilities, nursing homes, intermediate care facilities for persons with intellectual disabilities or related conditions, home health, and hospice. DSHS Healthcare Facilities staff is responsible for the non-long-term care survey and certification activities funded through the Title XVIII Medicare program. CMS funds these activities through an annual grant provided to the State of Texas.

Healthcare Facilities staff conducts activities under the direction of the State Operations Manual (SOM), in conjunction with specific directives provided by the CMS Dallas Regional Office and DSHS policies/procedures. The goal of survey and certification activity is to assure the quality of healthcare services delivery by participating providers and suppliers by verifying compliance with minimum requirements established under state law and the Medicare Conditions of Participation. Complaint and incident investigations are also part of these compliance activities.

Healthcare Facilities staff is also responsible for the survey and certification activities performed for the CLIA program, which is funded on a user fee basis, and is an annual grant from CMS. Healthcare Facilities staff carries out this activity under the direction of the SOM, in conjunction with specific directives provided by the CMS Dallas Regional Office and DSHS policies/procedures. The overall goal is to conduct survey and certification activities in a manner that validates laboratories meet the minimum standards under the CLIA program, while assuring that the health and safety of consumers are protected.

For state licensing, Medicare, and CLIA healthcare facility compliance activities, the Patient Quality Care Unit (PQCU) is responsible for scheduling surveys, hiring qualified survey staff, operating within federal budget allocations, and assuring that CMS and DSHS policies/procedures are followed. PQCU also provides data entry of the Medicare and CLIA surveys and information into the federal database systems, provides information to the public concerning rules and regulations, and submits selected survey documents to the Austin central office or the CMS Dallas Regional Office. PQCU consists of five zone offices across the state, located in the following cities: Houston, San Antonio, Arlington, Tyler, and Austin. There are two groups in Austin, one being exclusive to CMS work for certified-only facilities. The Substance Abuse Compliance Group in Austin handles all inspections and compliance activities for substance abuse treatment facilities and narcotic treatment programs.

A healthcare facility must be licensed in Texas if required by state law. The healthcare facility must pass an initial health survey, submit construction plans for review, and pass a final construction inspection and a life safety code survey (if applicable) to obtain a Medicare provider number, which allows the facility to submit healthcare-related claims to CMS for reimbursement. In addition, the provider usually must have a Medicare provider number before the facility can become a Medicaid provider. According to funding availability and prioritized workload, DSHS staff periodically conducts on-site surveys at health facilities to ensure continuing compliance with the applicable state and federal rules and regulations. When DSHS staff inspects a facility, or investigates a complaint and violations are determined, staff refers the matter to RSD, Enforcement Unit for possible state enforcement action, or to CMS for federal action.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/regulatory.shtm.

For more information, see:

- http://www.cms.hhs.gov/CertificationandComplianc/
- http://www.cms.hhs.gov/SurveyCertificationEnforcement/
- http://www.cms.hhs.gov/GuidanceforLawsAndRegulations/

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $5,565,433 |
| General Revenue | $2,688,887 |
| General Revenue-Dedicated | $1,097,369 |
| Other | $0 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| DADS | DADS promulgates the licensing rules for nursing facilities, assisted living facilities, intermediate care facilities for the individuals with intellectual disabilities or related conditions, adult daycare centers, and home and community support services agencies. DADS licenses these facilities, surveys them for compliance with state and federal regulations, and conducts complaint investigations for violations alleged to have been committed by facility staff. | DSHS does not regulate long-term healthcare facilities. DSHS regulates the non-long-term care healthcare facilities in Texas. |
| CMS | CMS maintains a panel of psychiatric consultant surveyors under contract to conduct initial | DSHS does not conduct these surveys, but does conduct federal complaint investigations in |

| Name | Similarities | Differences |
|---|---|---|
| | and recertification surveys of the two special conditions for psychiatric hospitals. CMS conducts two main types of surveys to validate state surveys:<br>• comparative surveys, in which a CMS team or contractor conducts an independent survey within 60 days of the state survey (to compare results); and<br>• observational surveys, in which a CMS team or contractor accompanies the state team to observe conditions at the facility, as well as the process of the state team. | psychiatric hospitals, as authorized by CMS. DSHS does not validate CMS surveys. There is open communication between agencies to discuss and resolve differences of opinion and to seek written interpretation. |
| CMS Approved Accreditation Organizations, for example, The Joint Commission (TJC) | TJC conducts surveys of health facilities. TJC awards accreditation for a provider type; the request for certification flows through DSHS to CMS. CMS approves the certification or deemed status. | TJC may announce some surveys. TJC is a private organization receiving compensation from facilities for conducting surveys. TJC has its own standards. Not all health facilities in Texas have or seek TJC accreditation and/or deemed status. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

The Social Security Act mandates the establishment of minimum health and safety standards, which providers and suppliers participating in the Medicare and Medicaid programs must meet. The Secretary of the DHHS has designated CMS to establish standards and the compliance aspects of these programs. Section 1864(a) of the Social Security Act directs the Secretary to use the help of state health agencies or other appropriate agencies when determining whether healthcare entities meet federal standards. This helping function is termed "provider certification."

Agreements between the DHHS Secretary and states stipulate that designated agencies performing provider certification will keep necessary and appropriate records to be provided as

required and employ management methods, personnel procedures, equal opportunity policies, and merit system procedures in accordance with agreed upon or established practices. The Secretary agrees to provide funds for the reasonable and necessary costs to the states for performing the functions authorized by the agreements. The lifetime of the agreements is unlimited, but either of the parties may terminate the agreement under specific conditions. State governors have the prerogative to propose modification of the agreements to allow for variations in organizational location of responsibilities with the state for federal programs and for state health facilities licensure. The state agency cannot re-delegate responsibility for evaluation and certification; however, the agency may assign subsidiary functions, such as the performance of surveys and investigations, to other state government units or other agencies, with the express approval of the DHHS Secretary. Modification or renegotiation of the agreement may be necessary if the reorganization of a state government affects the responsibilities of the designated agency, or in any way affects the arrangement previously recognized by the Section 1864 Agreement.

Effective September 1, 1999, the Texas Department of Human Services became the designated state agency for the Section 1864 Agreement. Effective September 1, 2004, the DADS assumed this responsibility. DADS is responsible for the Medicare survey and certification activities in nursing facilities, intermediate care facilities for individuals with intellectual disabilities or related conditions, and home and community support services agencies. As part of the 1864 Agreement, DSHS is responsible for the non-long-term care survey and certification activities, exclusive of home and community support services.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| CMS | CMS administers the standards compliance aspects of the Medicare and Medicaid programs. | DSHS is responsible for the non-long-term care survey and certification activities. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The program does not have any contracts.

**L. Provide information on any grants awarded by the program.**

The program does not award any grants.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory changes to assist the program in performing its functions.

**Chapter 241, Texas Health and Safety Code** – DSHS recommends revision of this statute to clarify the definition of general hospital, special hospital, and hospital premises. DSHS also recommends a revision to change the administrative hearing process for emergency orders and to allow the State Office of Administrative Hearings to conduct administrative hearings for regulatory contested and informal cases, instead of DSHS.

**Chapter 241, 251, and 243, Texas Health and Safety Code** – DSHS recommends a revision to increase authority up to $25,000.00 per violation per day for administrative penalties.

**General Appropriations Act** – The Narcotic Treatment Program (NTP), currently in the Food and Drug funding strategy, is more closely related to substance abuse facility regulation in the Health Care Facility funding strategy. NTPs provide an approved narcotic drug (methadone) for maintenance and/or detoxification and rehabilitative services to opium-addicted individuals.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

Texas has gained a reputation for its model survey program for ESRD facilities, which is performed under state licensing rules and state funding. The health and safety risks inherent with dialysis treatment necessitate close scrutiny of these providers. ESRD surveys have become a higher workload priority for the CMS in recent years. The state and federal regulations require DSHS to work closely with the ESRD network related to quality assurance and data provided by these facilities.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**

- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Licensing of healthcare facilities is necessary to protect the health and safety of consumers receiving care and services in those facilities. A license issued by DSHS establishes the right of that healthcare facility to operate in Texas, subject to ongoing compliance with applicable state statutes, rules, and regulations. The statutes and rules establish minimum health and safety standards that facilities must meet and maintain in order to provide healthcare services to patients. These standards include provisions for administration; qualifications, orientation, training, continuing education, and evaluation of staff; medical staff requirements; clinical records including confidentially and security of records; quality assurance requirements; emergency equipment and medical protocols; infection control surveillance; equipment sterilization standards; nursing, pharmaceutical, radiology, laboratory, and dietary services; physical plant and fire safety codes; and disposal of hazardous waste.

Healthcare Facilities staff verifies a facility's compliance with minimum standards through periodic on-site inspections, complaint investigations, follow-up inspections, and document review. In addition, Healthcare Facilities must comply with the applicable state and federal regulations in order to obtain and maintain Medicare or CLIA certification.

Applicable health and safety codes authorize statewide on-site inspections to verify compliance with statutes, rules, and corrective action plans. DSHS conducts inspections of regulated entities through on-site inspections, via mail, and by desk reviews. Staff may conduct on-site inspections for issuance of an initial license, renewal of a license, following a change of ownership, when the facility has not demonstrated compliance with standards, or in response to a complaint. DSHS conducts inspections for initial or license renewal purposes by performing a standard-by-standard review of all aspects of a facility's operation in order to determine compliance with licensing standards. This may include an on-site inspection as well as a desk review inspection. DSHS conducts Medicare and CLIA surveys and investigations according to the State Operations Manual developed by CMS. Certain health facilities undergo life safety code surveys, in addition to the health surveys. DSHS has procedures for inspections and complaint investigations of substance abuse facilities and NTPs.

The surveyor completes both a statement of deficiencies and a survey report documenting any deficiencies cited. The facility must prepare an acceptable plan of correction that includes the date that the facility expects to have the deficiency corrected. The surveyor may conduct on-site verification of corrections. If an immediate threat to patient health and safety exists, the surveyor may remain on site until the facility addresses the threat. The surveyor may refer the healthcare facility for state and/or federal enforcement action, if appropriate.

Facilities that endanger the health and safety of their patients by failing to demonstrate ongoing compliance with licensing rules and standards are subject to enforcement action

including injunctive relief, criminal and civil penalties, reprimand, administrative penalties, denial, suspension, and revocation of license. Medicare-certified and CLIA facilities are subject to termination for serious and/or recurring non-compliance.

Staff receives complaints against substance abuse facilities, NTPs, and non-long- term care facilities both by verbal and written communication. A complaint may be anonymous. To assure continuous intake of complaint information, DSHS maintains a 24-hour, toll-free hotline. Information and instructions on filing a complaint are on the DSHS website. The steps for handling consumer/public complaints against regulated entities are as follows.

1. Evaluate allegations to determine if a potential violation exists.
2. Evaluate allegations to determine if a referral to another regulatory body is appropriate.
3. Authorize an investigation if a potential violation exists.
4. Send referral letters to other regulatory bodies, as appropriate.
5. Notify complainant, if known, of whether an investigation will ensue and/or if staff made a referral to another regulatory body that has jurisdiction.
6. Conduct an investigation by going on-site, via mail or desk review, as appropriate.
7. Determine regulatory violations, if indicated. Notify complainant of investigative findings, if allowed per state and federal rules and regulations.
8. Take state enforcement action against a healthcare facility, as appropriate, or refer to CMS for termination process.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

| **Department of State Health Services<br>Healthcare Facilities Licensing<br>Exhibit 11: Information on Complaints Against Regulated Persons or Entities<br>Fiscal Years 2011 and 2012** | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| Total number of regulated persons | N/A* | N/A* |
| Total number of regulated entities** | 2,966 | 2,995 |
| Total number of entities inspected | 492 | 507 |
| Total number of complaints received from the public | 1,436 | 1,627 |
| Total number of complaints initiated by agency | 58 | 54 |
| Number of complaints pending from prior years | 0 | 0 |
| Number of complaints found to be non-jurisdictional*** | 385 | 436 |

| Department of State Health Services<br>Healthcare Facilities Licensing<br>Exhibit 11: Information on Complaints Against Regulated Persons or Entities<br>Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| Number of jurisdictional complaints found to be without merit | 671 | 781 |
| Number of complaints resolved | 1,172 | 1,350 |
| Average number of days for complaint resolution**** | 38 | 41 |
| Complaints resulting in disciplinary action:***** | | |
| administrative penalty | 10 | 17 |
| reprimand | 0 | 0 |
| probation | 1 | 3 |
| suspension | 0 | 0 |
| revocation | 0 | 0 |
| other | 3 | 0 |

Healthcare Facilities data is based on state performance measure reporting.

* N/A=Data not collected or tracked

** Does not include substance abuse facilities, NTPs or EMS; EMS excluded here since reported under Healthcare Professions

*** Based on Healthcare Facility complaint staff knowledge and experience, for every complaint logged into CMS Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS), approximately three more complaints are received that are non-jurisdictional.

**** Healthcare Facilities data from ACTS report (intake date to exit date)

***** These disciplinary actions are for all Healthcare Facilities, including EMS providers (EMS personnel are reported under the Professional Licensing Strategy), substance abuse, and NTPs.

| Department of State Health Services<br>Substance Abuse Licensing<br>Exhibit 11: Information on Complaints Against Regulated Persons or Entities<br>Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| Total number of regulated persons | N/A* | N/A* |
| Total number of regulated entities | 579 | 579 |
| Total number of entities inspected | 277 | 367 |
| Total number of complaints received from the public | 369 | 353 |
| Total number of complaints initiated by agency | 2 | 2 |
| Number of complaints pending from prior years | 4 | 0 |
| Number of complaints found to be non-jurisdictional | 34 | 23 |
| Number of jurisdictional complaints found to be without merit | N/A* | N/A* |
| Number of complaints resolved** | 349 | 334 |
| Average number of days for complaint resolution | 53 | 42 |
| Complaints resulting in disciplinary action: | | |
| administrative penalty | 0 | 1 |
| reprimand | 0 | 0 |
| probation | 0 | 0 |
| suspension | 0 | 0 |
| revocation | 0 | 0 |
| other | 0 | 0 |

* N/A=Data not collected or tracked

** Resolved=Closed, referred, or non-jurisdictional complaints

| Department of State Health Services<br>Narcotic Treatment Program (NTP) Licensing<br>Exhibit 11: Information on Complaints Against Regulated Persons or Entities<br>Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| Total number of regulated persons | N/A* | N/A* |
| Total number of regulated entities | 74 | 83 |
| Total number of entities inspected/surveyed | 41 | 43 |
| Total number of complaint investigations conducted | 10 | 16 |
| Total number of complaints received | 10 | 21 |
| Total number of complaints initiated by agency | N/A* | N/A* |
| Number of complaints pending from prior years | 4 | 13 |
| Number of complaints found to be non-jurisdictional | 0 | 1 |
| Number of jurisdictional complaints found to be without merit | 0 | 8 |
| Number of complaints resolved** | 1 | 34 |
| Average number of days for complaint resolution | 53 | 103 |
| Complaints resulting in disciplinary action: | | |
| administrative penalty | 1 | 1 |
| reprimand | 0 | 0 |
| probation | 0 | 0 |
| suspension | 0 | 0 |
| revocation | 0 | 0 |
| other | 0 | 0 |

* N/A=Data not collected or tracked

** Resolved=Closed, referred, or non-jurisdictional complaints

**Disease Control and Prevention (DCP) Services Division**
Jana Zumbrun, Assistant Commissioner

**FTEs: 859.5**

The DCP Services Division provides oversight, monitoring, and strategic direction for implementing programs that protect, promote, and improve the public's health by decreasing health threats and sources of disease. The division promotes healthful lifestyles and risk reduction to prevent chronic diseases and infectious diseases such as heart disease, diabetes, cancer, human immunodeficiency virus (HIV), sexually transmitted diseases (STD), and conditions associated with obesity, and implements programs to prevent injuries.

The division includes four sections that correspond to the types of services provided.

- Environmental Epidemiology and Disease Registries Section conducts investigations, health risk assessments, and ongoing disease surveillance, and maintains active disease registries.
- Health Promotion and Chronic Disease Prevention Section focuses on preventable chronic health conditions, including type 2 diabetes, high blood pressure, heart disease, stroke, and obesity.
- Infectious Disease Prevention Section manages program services related to tuberculosis (TB), STD, HIV, refugee health, perinatal hepatitis B, Hansen's disease, and immunizations for children and adults.
- Laboratory Services Section provides medical laboratory services for the state-mandated Newborn Screening Program, Texas Health Steps Program, Maternal and Child Health Program, Title V, and Childhood Lead Screening. The section also provides comprehensive diagnostic testing of specimens for the presence of infectious disease organisms and water testing under the federal Safe Drinking Water Act and manages the South Texas Laboratory.

Detailed information about each of these programs is in included in a separate Section VII description.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Environmental Epidemiology and Disease Registries |
| **Location/Division** | 1100 W. 49th Street, Austin - Disease Control and Prevention (DCP) Services Division |
| **Contact Name** | Janna Zumbrun, Assistant Commissioner, DCP Services Division |
| **Actual Expenditures, FY 2012** | $12,875,417 |
| **Number of Actual FTEs as of June 1, 2013** | 121.8 |
| **Statutory Citation for Program** | Chapters 82, 84, 87, 88, 92, 161, 427, 503, 773, and 777, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Environmental Epidemiology and Disease Registries have the primary objective to improve health status through disease registration and epidemiology, disease prevention and control, and toxicology surveillance. Major activities include the following.

- Conduct epidemiologic surveillance on child blood lead levels, traumatic injuries, emergency medical service runs, occupational conditions, and other non-communicable diseases.
- Initiate epidemiological and toxicological investigations and/or studies of disease clusters and harmful environmental exposures.
- Use environmental and health data to assess population-specific risks associated with potential exposures.
- Conduct education and outreach activities to reduce morbidity and mortality associated with environmental exposures.
- Create and maintain a registry of birth defects and compile/disseminate data about birth defect patterns in Texas.
- Monitor data for changes through time and place and respond to perceived changes in the occurrence of birth defects (cluster investigations).
- Participate in and facilitate research studies to help identify causes of birth defects.
- Support the education of the public and health professionals about the causes, surveillance, impact, and prevention of birth defects.
- Refer identified children and their families into services.
- Maintain a statewide population-based cancer registry that collects, manages, and analyzes high quality data about cancer cases and cancer deaths.
- Monitor cancer trends over time and determine cancer patterns in various populations.

- Guide planning and evaluation of cancer control programs (that is, determine whether prevention, screening, and treatment efforts are making a difference).
- Advance clinical, epidemiologic, and health services research.
- Provide information for a national database of cancer incidence.
- Maintain a statewide facility-based healthcare safety registry that collects, manages, and analyzes high quality data about healthcare-associated infections (HAIs) and preventable adverse events (PAEs) occurring in healthcare facilities.
- Conduct epidemiologic surveillance on HAIs and PAEs over time, including monitoring incidence and rates in facilities statewide.
- Guide planning and evaluation of infection prevention and patient safety quality improvement programs.
- Share information with the National Healthcare Safety Network (NHSN).
- Support the education of the public and health professionals about patient safety.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

Environmental Epidemiology and Disease Registries measure effectiveness and efficiency by evaluating the following key statistics.

| Number of Health Assessments and Consultations Provided During Previous 12 Months | | | |
|---|---|---|---|
| **Number of Health Assessments, Consults, Technical Assists** | **Population Affected** | **Number of Community Outreach and Educational Activities Provided** | **Population Receiving Mail Outs or Educational Materials** |
| 29 | ≈ 30,000 | 96 | 7,538 |

| 2012 Number of EMS/Trauma Registry Cases For Epidemiologic Analysis or Study | | | |
|---|---|---|---|
| **Number of Hospitals Reporting Cases** | **Number of Hospital Cases Reported** | **Number of EMS Providers Reporting Cases** | **Number of EMS Cases Reported** |
| 321 | 127,570 | 519 | 2,532,424 |

| 2012 Number of Childhood Lead Cases for Epidemiologic Analysis, Study, and Follow-up | | |
|---|---|---|
| **Number of Laboratories Reporting Child Blood Lead Levels** | **Total Number of Childhood Blood Lead Level Reports Received** | **Number of Children For Whom Blood Lead Levels were Received** |
| 255 | 467,871 | 389,405 |

| 2012 Number of Occupational Condition Cases For Epidemiologic Analysis or Study | |
|---|---|
| **All Occupational Reportable Diseases** | **Estimated Worker Population Bureau of Labor Standards** |
| 34,567 | 11,797,000 |

Key statistics for the Texas Cancer Registry (TCR) in 2012 are as follows.

- Collected 126 data items per cancer, including information on the type, extent, and location (site) of the cancer; type of initial treatment; demographic data; patient vital status over time; and cause of death.
- Received over 250,000 reports of cancer and maintained over 2 million cancer records with personally identifiable protected health information, as well as statutorily protected physician and healthcare facility information.
- Completed 295 data requests.
- Received 23,665 hits on the TCR web query tool.
- Provided complex technical assistance for 43 research studies.
- Published 42 peer-reviewed journal articles using TCR data.

Key statistics for the Texas Birth Defects Registry in 2012 are as follows.

- Reviewed 62,952 medical records.
- Re-reviewed 10,078 case finding entries (for quality assurance).
- Re-reviewed 3,142 medical records (for quality assurance).
- Re-abstracted 695 medical records (for quality assurance).
- Reviewed 10,712 cases by a clinical reviewer (for quality assurance).
- Mailed 13,441 referral brochures to families.
- Visited 238 facilities for routine active surveillance activities.
- Published 15 journal articles using Birth Defects Epidemiology and Disease Surveillance data.
- 2,473 hours of birth defects training received by regional staff.

Key statistics for the Child and Adult Blood Lead Program in 2012 are as follows:

- 3,902 child blood lead tests ≥ 10 µg/dL;
- 878 case coordination calls to follow-up with providers on children with elevated blood lead levels;
- 3,388 notification letters to parents of children with elevated blood lead levels;
- 31,891 adult blood lead tests received;
- 2,386 adult blood lead tests ≥ 10 µg/dL; and
- 2,195 notification letters to adults with elevated blood lead levels.

Key statistics for HAI reporting (using Maven software) in 2012 are as follows:

- 891 healthcare facility records included;
- 320 healthcare facilities reporting HAI to Texas;
- 964 Maven user accounts;

- 122,527 procedure records, 1,562 surgical site infection records, and 1,235 bloodstream infections in Maven;
- 2 data requests completed;
- 1,380 Maven-generated, facility-specific reports posted on a public website; and
- 18 facilities underwent site visits to audit >114 medical records.

PAE reporting is still in the process of developing a secure electronic reporting interface.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1979** – House Bill 853 establishes the Texas Cancer Control Act, requiring the Texas Board of Health to establish and maintain a statewide cancer registry.

**1985** – In response to concerns raised about ethylene dibromide in grain products, the Texas Department of Health (TDH), predecessor to DSHS, establishes the Environmental Epidemiology Division, predecessor of the Environmental and Injury Epidemiology and Toxicology Unit. TDH directs the division to assess the public health impact of environmental exposures and to make recommendations related to the abatement of the exposures to protect public health.

**1989** – The Legislature establishes the Health Risk Assessment of Toxic Substances and Harmful Physical Agents Act and the Reporting of Occupational Conditions Act and assigns duties to DSHS.

**1993** – House Bill 87 mandates creating an active, statewide birth defects registry, as concerns about the perceived high rates of birth defects along the Mexico border intensify when three anencephalic babies are delivered in a Brownsville hospital within two-day period. The Legislature also establishes the Injury Prevention and Control Act and the Epidemiologic or Toxicologic Investigations Act and assigns duties to DSHS.

**1994** – The Centers for Disease Control and Prevention (CDC) award the TCR its first National Program of Cancer Registries (NPCR) grant. TCR becomes a part of the national cancer surveillance system; however, data does not meet sufficient quality standards for inclusion in national data sets or publications.

**1995** – The Legislature establishes the Reports of Childhood Lead Poisoning Act and assigns responsibilities for the collection of data to DSHS.

**1996** – The CDC awards the Texas Birth Defects Registry a grant to establish the Texas Center for Birth Defects Research and Prevention, which is still in operation and successful 14 years later. The purpose is to foster collaborative population-based epidemiologic and genetic

research with academic institutions in Texas, and to design and conduct the National Birth Defects Prevention Study.

**1999** – The Texas Birth Defects Registry becomes statewide.

**2001** – The Legislature establishes the Texas Environmental Health Institute Act, which requires TDH and the Texas Commission of Environmental Quality to examine jointly ways to identify, treat, manage, prevent, and reduce health problems associated with environmental contamination.

**2003** – TCR meets CDC-NPCR high quality data standards for the first time, allowing for its data to be included in national cancer data sets and publications.

**2003** – The Texas Birth Defects Registry becomes a member of the International Clearinghouse for Birth Defects Surveillance and Research.

**2006** – TCR attains Gold level certification from the North American Association of Central Cancer Registries for the first time. TCR continues to maintain this Gold level certification today.

**2007** – Senate Bill 288 mandates HAI reporting.

**2009** – Senate Bill 203 mandates PAE reporting. CDC's NHSN receives approval as the HAI data collection system.

**2010** – TCR becomes one of 10 "Specialized Comparative Effectiveness Research Cancer Registries," as part of a collaboration between the NPCR, Office of Genomics at CDC, and the Agency for Healthcare Quality and Research.

**2011** – HAI reporting begins.

**2012** – DSHS posts first HAI data on the agency website for public viewing.

**2013** – DSHS completes phase-in of all HAI reporting.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

Environmental Epidemiology and Disease Registries affect the health of all Texans through information and analysis of disease surveillance and disease registry data. A wide range of researchers, communities, and policymakers use the data to understand the causes of disease

and to develop prevention and control strategies. DSHS has no qualifications or eligibility requirements for persons or entities affected.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The Environmental and Injury Epidemiology and Toxicology Unit, along with the Cancer Epidemiology and Surveillance Branch and the Birth Defects Epidemiology and Surveillance Branch, are in the DCP Services Division, Environmental Epidemiology and Disease Registries Section. The staff of Environmental and Injury Epidemiology and Toxicology Unit consists of the Epidemiology Studies and Initiatives Branch, the Blood Lead Surveillance Group, the Injury and Emergency Medical Services/Trauma Registry Group, and the Exposure Assessment Surveillance and Toxicology Group. These staff positions are located in Austin.

TCR has staff in the central office and three DSHS regional offices (San Antonio, Arlington, and Houston). These offices serve all DSHS health service regions (HSRs). The Texas Birth Defects Epidemiology and Surveillance Branch staff conducts registry operations through 60 full-time equivalent staff, 50 of whom are centrally supervised but housed in DSHS regional offices.

The Texas Health Care Safety Group oversees HAI and PAE reporting, and consists of 11 positions: 8 in the central office and 3 centrally supervised but housed in DSHS regional offices. HAI/PAE reporting covers all DSHS HSRs.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/pps.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $4,649,790 |
| General Revenue | $3,557,757 |
| General Revenue-Dedicated | $1,611,723 |
| Other | $3,056,147 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

Currently, no internal or external programs provide identical functions.

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

Environmental Epidemiology and Disease Registries staff coordinates activities that involve multi-jurisdictional efforts with participating agencies to avoid duplication and conflict. This is accomplished both through meetings, such as those involving the Toxic Substances Coordinating Committee, and through consistent communication with appropriate programs within the other agencies. Staff refers activities that clearly fall within the jurisdiction of another agency to that agency.

The Birth Defects Registry links with the vital statistics system to obtain and confirm an array of demographic information. In addition, the registry makes periodic checks with the birth defects data collected on birth certificates to monitor concordance of both systems.

TCR staff participates in monthly meetings with other DSHS CDC-funded cancer programs (Comprehensive Cancer Control and the Breast and Cervical Cancer Screening Program) to discuss current activities and ensure coordination. DSHS and the Cancer Prevention and Research Institute of Texas (CPRIT) have a memorandum of understanding related to collaborating on TCR and establishing an executive committee. In 2010, DSHS and CPRIT signed an interagency contract establishing a TCR "footprint" of four TCR positions co-located at CPRIT.

HAI and PAE reporting staff has worked extensively with the Center for Health Statistics to avoid duplicating reporting requirements for facilities.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Local health departments (LHDs) | LHDs focus on issues related to the general health of citizens and compile statistics about health issues in their areas. | DSHS provides CDC funds to LHDs to fight child lead poisoning. DSHS also works with LHDs to assess the potential public health impact of environmental contaminants. |

**Regional Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Regional Advisory Councils (RACs) | Texas has 22 RACs organized to facilitate the development, implementation, and operation of a comprehensive regional emergency medical service (EMS) and trauma system, based on accepted standards of care to decrease morbidity and mortality. | RACs provide EMS and trauma data to DSHS. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| CDC | CDC is the primary federal agency responsible for public health. | DSHS provides data on child blood lead levels and childhood blood lead poisoning prevention activities to CDC. |
| CDC, National Center for Birth Defects and Developmental Disabilities (NCBDDD) | NCBDDD promotes child development, prevents birth defects and developmental disabilities, and enhances the quality of life for persons with disabilities. | NCBDDD provides funding and technical support for Texas Center for Birth Defects Research and Prevention, and coordinates the National Birth Defects Prevention Study and data sharing with other states. DSHS and NCBDDD provide mutual support in developing state birth defects surveillance programs through the National Birth Defects Prevention Network. |
| CDC, NHSN | NHSN is a tracking system for multiple healthcare safety metrics. | CDC manages and supports the NHSN, which is the system DSHS uses for collecting reports of HAIs from hospitals and ambulatory surgical centers in Texas. |
| CDC, NPCR | NPCR collects data on the occurrence of cancer; the type, extent, and location of the cancer; and the type of initial treatment. | NPCR partially funds TCR under a cooperative agreement. |
| Environmental Protection Agency (EPA) | EPA protects human health and the environment. | EPA provides data necessary to evaluate the potential public health impacts of environmental contaminants. |

| Name | Description | Relationship to DSHS |
|---|---|---|
| National Institute of Occupational Safety and Health (NIOSH) | NIOSH is responsible for conducting research into occupational safety and health matters. | NIOSH provides funds for occupational condition surveillance. |
| U.S. Department of Health and Human Services, Agency for Toxic Substances and Disease Registry (ATSDR) | ATSDR serves the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures and disease related to toxic substances. | ATSDR provides funds for health assessment and consultation activities and for surveillance of amyotrophic lateral sclerosis. |
| National Highway Traffic Safety Administration (NHTSA) | NHTSA is part of the Department of Transportation. Its mission is to save lives, prevent injuries, and reduce vehicle-related crashes. | NHTSA indirectly provides funds to the DSHS EMS/Trauma Registry through grants to the Texas Department of Transportation. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

Contracts established in this program focus on environmental epidemiology, toxicology, occupational disease, and injury surveillance, and are aligned with those health registries that most commonly have an environmental health science focus. DSHS establishes contracts to handle the following activities.

- Develop statewide surveillance and registry systems.
- Collect complete, timely, and accurate population-based cancer incidence data.
- Provide agreements for data sharing between agencies.
- Complete clinical reviews of birth defects cases.
- Provide epidemiological surveillance activities and support.
- Identify and investigate disease clusters that may be linked to environmental conditions.
- Identify patterns of injury that may be linked to environmental and other factors.
- Improve early detection and investigation capabilities of poison control centers.

Amount of contracted expenditures in fiscal year 2012: $957,372
Number of program contracts: 43 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $116,025 | Texas A&M University | Review birth defect cases from Texas Birth Defects Registry |
| $82,209 | University of Texas at Austin | Review birth defect cases from Texas Birth Defects Registry |
| $65,719 | Texas A&M University | Review birth defect cases from Texas Birth Defects Registry (additional contract) |
| $64,188 | University of Texas School of Public Health | Review birth defect cases from Texas Birth Defects Registry |
| $60,594 | Dallas County Hospital District | Improve early detection and investigation capabilities of Poison Control Centers |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to ensure accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs targeted financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system (SOURCE.Net) to document contractor information, contract management activities, and monitoring reports and other reports. DSHS knows of no contracting problems.

## L. Provide information on any grants awarded by the program.

DSHS awards grants in this program for the following services.

- Develop statewide surveillance and registry systems.
- Collect complete, timely, and accurate population-based cancer incidence data.
- Provide agreements for data sharing between agencies.
- Complete clinical reviews of birth defects cases.
- Provide epidemiological surveillance activities and support.
- Identify and investigate disease clusters that may be linked to environmental conditions.

- Identify patterns of injury that may be linked to environmental and other factors.
- Improve early detection and investigation capabilities of poison control centers.

Using sub-recipient contracts, the program awards grants in the following manner:
- through legislative mandate that requires DSHS to directly negotiate and execute grant contracts to poison control centers;
- on an emergency or sole source basis when an approved emergency or sole source justification waives competition; and
- to a state or local governmental entity through direct negotiation and grant contract execution (these entities are exempt from competition).

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory changes to assist the program in performing its functions.

**Data Sharing** – DSHS recommends statutory changes to facilitate data sharing among departmental programs for public health purposes. Facilitating the sharing of data could serve to improve public health capacity. Sharing data will allow patients to be tracked across different programs; reduce the burden on hospitals and other reporters; improve the quality and completeness of data across DSHS programs; increase the ability of DSHS disease registries to identify new and existing cases; and increase efficiencies in case finding, data collection, and quality assurance activities.

**Chapter 81, Texas Health and Safety Code** – DSHS recommends revision of this code to define health information exchange (HIE) as organizations that facilitate the transmission and exchange of electronic health records and to provide explicit authority for DSHS programs to exchange data with HIEs. Healthcare providers, facilities, and medical groups may form HIEs or establish business associations with HIEs.

**Chapter 92 and Chapter 773, Texas Health and Safety Code** – DSHS recommends revision of this code to allow the release of injury/trauma/EMS data to promote injury/trauma/EMS research. The absence of the research provision limits the use of the data in assessing the Texas EMS and Trauma system and understanding the causes of injury.

**Chapter 98, Texas Health and Safety Code** – DSHS recommends revision to this code to add PAE reporting, as the events are phased in.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

Disease registries are primary sources of data for prevention and control of diseases. Population-based registries collect disease data from numerous sources such as LHDs, hospitals, healthcare providers, and physicians. The epidemiology data obtained from registries are necessary to understand the burden of disease and trends over time, among population subgroups, or within geographic areas. Epidemiology and surveillance data are vital in identifying the causes of disease, effectiveness of treatment, and outcomes. The coordinated analysis of health and environmental data provides the best means of assessing population-specific risks and examining ways to identify, treat, manage, prevent, and reduce health problems associated with environmental contamination and other exposures. DSHS and others use data and information from these activities to investigate the causes of disease and injury, to direct actions to populations most in need, and to evaluate the success of public health interventions.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Infectious Disease Prevention |
| **Location/Division** | 1100 W. 49th Street, Austin - Disease Control and Prevention Services (DCP) Services Division |
| **Contact Name** | Janna Zumbrun, Assistant Commissioner, DCP Services Division |
| **Actual Expenditures, FY 2012** | $294,943,769 |
| **Number of Actual FTEs as of June 1, 2013** | 653.3 |
| **Statutory Citation for Program** | Chapters 81, 85, 89, and 161, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

The Infectious Disease Prevention Program has the primary objective to reduce the occurrence and control the spread of preventable infectious diseases, including:

- human immunodeficiency virus (HIV) and sexually transmitted diseases (STD) and provide treatment and care for persons with HIV,
- tuberculosis (TB) and Hansen's disease,
- zoonotic diseases, and
- emerging and acute infectious diseases.

Major activities include the following.

**Texas HIV Medication Program**

The Texas HIV Medication Program provides treatment medications for prescription drugs to low-income HIV-infected Texans who are uninsured or underinsured. The program operates an HIV State Pharmacy Assistance Program (SPAP) that assists low-income HIV-infected Texans with out-of-pocket costs associated with the Medicare Part D prescription drug benefit.

**HIV Care Services**

The HIV Care Services Program provides funding to local providers to secure medical and social support services for eligible HIV-infected Texans.

**HIV/STD Prevention and Intervention Services**

The HIV/STD Prevention and Intervention Services Program contracts with local health departments (LHDs) and community-based organizations to provide public information and health education services; HIV and STD screening, testing, and counseling; evidence-based

behavior change interventions; disease intervention services; and support for HIV/STD community planning.

**HIV/STD Surveillance**
The HIV/STD Surveillance Program oversees a statewide HIV/STD disease surveillance system and monitors trends in HIV/STD. The program manages data systems and provides data and analysis used for planning HIV prevention and services activities. The program also submits required HIV/STD surveillance and epidemiology data to the Centers for Disease Control and Prevention (CDC).

**Adult Viral Hepatitis Prevention Coordination Services**
The Adult Viral Hepatitis Coordination Services Program promotes integration of viral hepatitis prevention and care activities in agency and community health services.

**TB Prevention and Control Program**
The TB Prevention and Control Program supports a spectrum of disease prevention and control activities to manage persons diagnosed with TB effectively, including persons suspected of having TB and persons with latent TB infection. Services include screening and testing; clinical assessment, diagnosis and treatment; medical case management; and expert medical and nursing consultation. The program also supports case finding, contact investigation, and outbreak response. The program develops policies and procedures to guide the management of TB disease and infection statewide, to include directly observed therapy, genotyping, interferon gamma release assay testing, and tuberculin skin test screening in correctional facilities and other high-risk settings.

**TB Surveillance**
The TB Surveillance Program oversees a statewide TB disease surveillance system and monitors trends in TB disease. The program also manages data systems and submits required TB surveillance data to CDC.

**Hansen's Disease Program**
The Hansen's Disease Program provides outpatient treatment for individuals with Hansen's disease, also known as leprosy. Services include a physician's evaluation and treatment, diagnostic studies, medication, patient education about Hansen's disease and how to prevent disabilities from Hansen's disease, and referral for specialized medical services to treat other conditions resulting from Hansen's disease effectively. DSHS oversees all outpatient treatment services and provides expert medical and nursing consultation on Hansen's disease.

**Refugee Health Program**
The Refugee Health Program provides health assessments and referrals to newly arrived official refugees and other program-eligible clients, such as victims of human trafficking, parolees, asylees, and persons with special immigrant visas. Health assessments involve screening for communicable diseases such as TB, HIV, syphilis, and hepatitis. The assessments also screen for malaria, intestinal parasites, pregnancy, lead poisoning, nutrition-related conditions, and vision

and hearing. The program conducts these assessments and administers federally recommended immunizations no later than 90 days after individuals arrive in the United States. The program also provides referrals for specialized medical care based on screening results.

**Zoonosis Control**

The Zoonosis Control Program seeks to prevent the transmission of diseases from animals to humans through epidemiologic measures, intervention strategies, and educational efforts. The program covers prevention of reptile-associated salmonellosis; euthanasia of animals; housing of dangerous wild animals; inspection of rabies quarantine facilities and control of rabies; dispersal of Animal Friendly Fund appropriations; and requirements for circuses, carnivals, and zoos. The program also approves sponsors and curricula for euthanasia training courses for animal shelter employees and maintains an investigative response team of trained personnel capable of mobilizing on short notice to carry out collection, preparation, and submission for analysis of biological specimens.

**Oral Rabies Vaccination Program (ORVP)**

ORVP prevents reentry of domestic dog-coyote rabies variant in South Texas and controls the gray fox rabies variant in West-Central Texas. The program eliminates the disease by breaking the cycle of disease transmission through distribution of oral rabies vaccine bait to the reservoir species in designated zones by airplane, helicopter, and hand baiting.

**Distribution of Rabies Biologicals**

DSHS procures and distributes anti-rabies biologicals for treatment of persons exposed to rabies. Regional staff in the Zoonosis Control Program carries out this process.

**Animal Control Officer Training**

The Animal Control Officer Training Program prescribes standards and curriculum for basic and continuing education courses for animal control officers, delivers courses, and approves courses delivered by sponsors.

**Emerging and Acute Infectious Disease**

The Emerging and Acute Infectious Disease Program develops policies and procedures to control communicable diseases, and conducts and coordinates surveillance for over 45 communicable diseases to track trends in disease occurrence and to detect new and emerging diseases. The program coordinates surveillance for specific healthcare-associated infections and monitors the occurrence of communicable diseases to identify changes that might indicate common exposure or new routes of transmission. Additionally, the program responds to inquiries from the public and medical communities regarding the occurrence, prevention, and control of communicable diseases and provides guidance to physicians and other medical staff in diagnosis of clinical illnesses. The program coordinates responses to disease outbreaks among LHDs, regional health departments, other DSHS programs, federal agencies, and other state agencies, and conducts analytical studies to identify emerging infectious diseases and their risk factors.

**ImmTrac**
ImmTrac is the statewide, lifespan immunization registry for first responders, adults, and children and serves as Texas' tracking and reporting system for vaccines, antivirals, and other medications given in preparation for or in response to a disaster.

**Texas Vaccines for Children (TVFC)**
The TVFC Program recruits and provides vaccine to over 3,600 clinic sites, as well as conducting quality assurance site visits annually on those clinic sites.

**Texas Immunization Services Working Group (TISWG)**
DSHS created TISWG based on a recommendation of various studies and legislation during the 78th Legislature, Regular Session, 2003. The purpose of TISWG is to raise vaccine coverage levels and improve immunization practices by increasing partnerships across the state. TISWG has members representing all areas of the statewide immunization system for children, and focuses on improving the system and increasing vaccine coverage levels. Members discuss system improvements, and may promote action steps in the organizations they represent.

**Immunization Media Campaigns**
The Immunizations Program conducts media campaigns annually as a key part of informing the public about the importance of immunizations.

**Perinatal Hepatitis B Prevention Program**
The Perinatal Hepatitis B Prevention Program promotes screening of all pregnant women for hepatitis B surface antigen (HBsAg) at the first prenatal visit and at delivery, and administration of the hepatitis B vaccine to all newborns prior to hospital discharge or within 12 hours of birth to neonates born to HBsAg positive women. At-risk newborns also receive hepatitis B immune globulin within seven days of birth. The program sets standards of care for maternal screening and case management services for newborns to HBsAg positive mothers, including susceptible household contacts and sexual partners. The program develops educational materials to increase provider and patient awareness of hepatitis B and its long-term effects on infants born to HBsAg positive mothers.

**Immunization Contracts with Local Health Departments**
The Immunization Program contracts with LHDs to ensure continuity of immunization services at the local level.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

The Infectious Disease Prevention Program measures the effectiveness and efficiency of its various activities by implementing evidence-based practices, evaluating program activities, and

analyzing relevant data. The following are examples of the methods used in some of the individual areas.

**Texas HIV Medication Program**

- In fiscal year 2012, the program served 17,235 clients.
- Data indicate that patients who receive HIV medications have significantly lower inpatient hospital costs than patients not receiving the medications. Effective treatment helps keep many Texans healthy enough to work who would otherwise progress to disability and reliance on costly public health care.
- Appropriate HIV treatment generally slows the progression of the disease and the resultant damage to the immune system. Patients whose immune systems are more intact have, on average, lower healthcare costs than those with damaged immune systems.

**HIV Care, Prevention, and Surveillance Services**

- Research proves that HIV medical care and supportive services slow the progression of HIV infection to symptomatic disease. This results in reduced costs for unnecessary hospitalization and emergency room visits. Annually, approximately 30,000 Texans with HIV infection access various medical and social services supported by federal and state funding, meaning that almost half of the persons living with HIV in Texas have received services through these systems.
- HIV/STD prevention activities reduce the spread of serious and life-threatening diseases. Each avoided case of HIV results in substantial savings in lifetime medical care costs. Most HIV prevention programs funded by DSHS need to avert only one new HIV infection per year to be cost saving. The consensus figure for lifetime medical care costs for a person with HIV is $385,200 (calculated in 2004 dollars).
- In HIV testing programs funded by DSHS, about 95 percent of persons testing positive receive those test results. This provides an opportunity to provide prevention counseling and to link persons to medical care and additional prevention programming.
- In fiscal year 2012, the public health system notified 6,397 persons of possible exposure to syphilis (partners), and 4,990 others who were considered to be at risk of contracting syphilis, but were not directly exposed. There were 2,626 partners treated for the onset of incubating disease. Of the 6,397 partners notified, 807 tested positive for syphilis and were appropriately treated. In addition, screenings identified 109 pregnant women who required public health follow-up and 60 women received treatment for syphilis, thus avoiding transmission of the disease to their children. Data suggest every $1 spent on early gonorrhea and chlamydia detection and treatment saves $12 in associated costs. Quality surveillance allows DSHS to track and document changes in the HIV and STD disease trends, allowing better planning and implementation of effective interventions.

**TB Prevention and Control Program**

- In fiscal year 2012, DSHS received reports of 1,297 persons diagnosed with TB. TB is a reportable condition in Texas.

- Of that number, nine had multi-drug-resistant (MDR) TB. MDR TB requires prolonged treatment averaging 24 months when compared to 9 months of treatment for non-MDR TB patients.
- In 2010, the latest year in which therapy completion data are available, 86 percent of patients completed treatment for TB.

**Hansen's Disease Program**

- In fiscal year 2012, DSHS received reports of 11 persons diagnosed with Hansen's disease. Hansen's disease is a reportable condition in Texas.
- Hansen's disease presents in two forms, with each having its own treatment period. The treatment for paucibacillary disease is 12 months, and for multibacillary disease is 24 months. The program monitors disease completion rates to determine program effectiveness.

**Refugee Health Program**

- In federal fiscal year 2012, 5,908 refugees resettled in Texas. All refugees and program eligible clients, such as victims of human trafficking, parolees, asylees, and persons with special immigrant visas, are eligible to receive health assessment screenings within 90 days of arrival or status designation.
- The CDC Immigrant, Refugee, and Migrant Health Branch provides guidelines for screening refugees and program-eligible clients. The DSHS Refugee Health Program establishes performance benchmarks for each recommendation.
- In federal fiscal year 2012, 94 percent of eligible refugees received physical examinations. CDC recommends that a minimum of 90 percent of eligible clients receive a physical examination.
- In federal fiscal year 2012, 99 percent of eligible clients received TB screenings. TB is endemic in many underdeveloped and war-torn countries in which refugees and other eligible clients are born. To prevent exposure to TB, at least 95 percent of all eligible clients must complete TB screening within 90 days of arrival in the United States.

**Zoonosis Control**

- ORVP eliminated domestic dog-coyote variant rabies from Texas through annual aerial and hand distribution of oral rabies vaccine bait units across South Texas, thereby vaccinating a percentage of the coyote population sufficient to break the cycle of disease transmission. Canine variant rabies persists in Mexico; therefore, ORVP maintains a vaccine-baited zone on the Texas-Mexico border to prevent incursion of the disease into Texas.
- ORVP has used the same strategy and tools to reduce the area impacted by gray fox variant rabies in West-Central Texas, thereby reducing the rabies exposure risk to people and domestic animals. DHS has identified one case of Texas fox variant rabies since May 2009, and DSHS took a contingency action in May 2013 to eliminate that focus of infection. DSHS has enhanced surveillance to gauge the effectiveness of the actions taken. A U.S. Department of Agriculture (USDA)-sponsored benefit/cost economic analysis of the ORVP

domestic dog-coyote project determined that Texas receives $3.50 to $13 in benefit for each $1 expended on the project.

- In fiscal year 2012, Zoonosis Control regional staff trained 38 animal control officers (ACOs) at 15 ACO Basic Training courses and provided other continuing education training opportunities for ACOs and local rabies control authorities.
- In fiscal year 2012, Zoonosis Control regional staff approved approximately 117 euthanasia training courses for animal shelter employees.
- In fiscal year 2012, 592 students successfully completed approved euthanasia courses.
- In fiscal year 2012, Zoonosis Control staff approved an estimated 327 non-DSHS basic and continuing education courses.
- In fiscal year 2012, DSHS distributed $579,998 in revenue from the sale of specialized Animal Friendly license plates to 16 recipient organizations. Under these grants, 10,470 no-cost or low-cost spay and neuter procedures have been performed on privately owned dogs and cats. Sterilization procedures performed under this program have prevented the birth of countless numbers of puppies and kittens. Controlling the population of unwanted and stray animals reduces the risk of animal bites and zoonotic diseases such as rabies.
- Zoonosis Control regional staff inspected approximately 224 quarantine facilities statewide in fiscal year 2012.
- In fiscal year 2012, Zoonosis Control regional staff distributed 642 courses of rabies post-exposure treatment.

**Emerging and Acute Infectious Disease**

- The Emerging and Acute Infectious Disease Program collects more than 32,000 disease reports annually and verifies accuracy of data in the reports.
- Surveillance activities have identified important emerging diseases such as methicillin-resistant Staphylococcus aureus (MRSA) infections, cryptosporidiosis, and shiga toxin-producing Escherichia coli.
- During the past few years, surveillance activities have detected three nationwide salmonellosis outbreaks traced to consumption of papayas, sushi, and cucumbers.
- Surveillance activities in Texas contributed to the rapid detection of vaccine-preventable disease cases in the United States and resulted in rapid control measures minimizing transmission.
- Texas has participated in ongoing surveillance of influenza and other acute respiratory diseases that have emerged internationally.

**Immunization Program**

The Immunization Program uses the National Immunization Survey (NIS) to assess effectiveness and efficiency. The NIS is an annual national survey conducted by CDC to assess immunization levels among pre-school children and adolescents. The survey provides information on immunization coverage for each state and select urban areas, as well as the nation. Texas uses the data to identify groups at risk of vaccine-preventable diseases and to evaluate trends in coverage.

Texas increased 4.1 percentage points in childhood immunizations coverage rates from 2008 to 2011, based on NIS data of children 19-35 months of age. Coverage is for the recommended 4:3:1:3:3:1:4 immunization series initiated in 2008, which includes four doses of diphtheria/tetanus/pertussis vaccine, three doses of poliovirus vaccine, one dose of measles/mumps/rubella vaccine, three doses of *Haemophilus influenzae* type b (Hib) vaccine, three doses of hepatitis B vaccine, one dose of varicella vaccine, and four doses of pneumococcal vaccine. The decrease in series coverage in 2009 is likely due to the Hib vaccine shortage. The percentage coverage rates are as follows:

- 2008 – 70.5 percent,
- 2009 – 67.6 percent,
- 2010 – 70.1 percent, and
- 2011 – 74.6 percent.

A substantial increase in human papillomavirus (HPV) vaccine series uptake occurred in Texas based on NIS data. The frequency of Texas females 13 to 17 years of age who received one or more HPV vaccine doses increased 17.2 percentage points from 2008 to 2011. The percentage coverage rates are as follows:

- 2008 – 31.6 percent,
- 2009 – 37.6 percent,
- 2010 – 47.5 percent, and
- 2011 – 48.8 percent.

Pneumococcal vaccine coverage levels in Texas adults 65 years of age and older increased 4.6 percentage points based on Behavioral Risk Factor Surveillance System (BRFSS) coverage data from 2008 to 2010. The percentage coverage rates are as follows:

- 2008 – 63.9 percent,
- 2009 – 66.0 percent, and
- 2010 – 68.5 percent.

The BRFSS 2011 prevalence data should be considered a baseline year for data analysis and are not directly comparable to previous years of BRFSS data, because of the changes in weighting methodology and the addition of the cell phone sampling frame. Therefore, 2011 data cannot be compared to 2010.

**Perinatal Hepatitis B Prevention Program**

- DSHS received reports of 688 HBsAg positive pregnant women in fiscal year 2012.
- DSHS received reports of 542 infants born to HBsAg positive mothers in fiscal year 2012. The National Health and Nutrition Examination Study estimates include 800 to 1,200 births each year to HBsAg positive mothers in Texas.
- 96 percent of infants born to HBsAg positive mothers in fiscal year 2012 received the first dose of the hepatitis B immune globulin within 12 hours of birth. Immunoprophylaxis administered within 12 hours of birth sharply curtails the development of perinatal hepatitis

B and chronic hepatitis B infection; however, all at-risk infants must complete the vaccine series to receive adequate protection.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**2001** – The Legislature enacts revisions to Chapter 822, Texas Health and Safety Code, requiring owners to register their dangerous wild animals with their local animal registration agency and file copies of their certificates with the legacy Texas Department of Health (TDH). Amendments to Chapter 81, Texas Health and Safety Code, require signs and flyers at retail pet stores warning customers about reptile-associated salmonellosis. Legislation directs TDH to promulgate rules pertaining to the format and content of the written warnings.

**2003** – The Legislature enacts revisions to Chapter 821, Texas Health and Safety Code, adding limits to the forms of euthanasia that animal shelters may administer to dogs and cats in their custody. Legislation directs TDH to develop rules concerning requirements for the use of sodium pentobarbital and commercially compressed carbon monoxide, and to approve sponsors and curricula for training euthanasia technicians.

**2007** – The Legislature amends Chapter 829, Texas Health and Safety Code, mandating basic and continuing education training of ACOs and directing DSHS to prescribe standards and curriculum for training courses, to deliver courses, and to approve sponsors and sponsor-delivered courses.

**2012** – CDC releases the funding opportunity announcement for the new HIV Prevention Grant cycle. The new guidance for funding includes the following categories:

- Category A: Core HIV Prevention – 75 percent must be spent on targeted HIV testing and linkage to care; condom distribution in high-risk groups; prevention with positives, including adherence, biomedical intervention, and perinatal prevention; policy; and administration.
- Category B: Expanded Testing – Activities will remain the same as those supported under PS10-10138 (HIV testing in healthcare settings and testing in non-healthcare settings); focus will be on Blacks, Latinos, homosexual men, and injecting drug users.
- Category C: Innovative Demonstration Projects – Innovative activities to enhance testing, linkage, integration of biomedical, use of technology, and innovative use of CD4 and viral load data.

**2012** – Due to new requirements, certain entering college students must present proof of receiving a meningococcal conjugate vaccine (MCV4) within the past five years. The new college requirement increases the demand for meningococcal vaccine and conscientious exemptions in both adolescents and adults.

**2013** – DSHS posts the request for proposal for HIV Prevention Projects. Approximately $10,000,000 is available to fund approximately 30 contracts in fiscal year 2013. DSHS develops the HIV Prevention funding opportunity to align with the National HIV/Acquired Immunodeficiency Syndrome (AIDS) Strategy as well as the state Community Planning Groups HIV/Sexually Transmitted Diseases Prevention Plan 2011. The 2010 National HIV/AIDS Strategy includes three primary goals: reduce the number of people who become infected with HIV, increase access to care and optimize health outcomes for people living with HIV, and reduce HIV-related health disparities.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

**HIV Care, Prevention, and Surveillance Services**

The program affects Texans with HIV infection and other STDs, as well as those at high risk of exposure to these diseases. Eligibility requirements for receiving HIV medications include proof of HIV infection, Texas residency, income at or below 200 percent federal poverty level (FPL), and uninsured or underinsured status. Eligibility requirements for receiving HIV care and treatment services include proof of HIV infection and Texas residency. HIV and STD prevention services are available to all who are infected, who may have been exposed, or who are at high risk of infection.

In fiscal year 2012, 17,235 persons received HIV medications. The HIV/STD surveillance program obtains required disease reporting data used to monitor and analyze disease trends. The program uses surveillance data and analysis for planning HIV/AIDS prevention and services activities, thus affecting populations at risk for getting HIV and/or other STD, and populations already infected with HIV and/or STD. LHDs and regional health departments that provide disease intervention and share services also use surveillance data. The program provides a statistical breakdown of persons served in the *HIV/STD Annual Report*, available at: http://www.dshs.state.tx.us/hivstd/info/annual.shtm

**TB and Hansen's Disease Control Programs**

TB and Hansen's disease services are available to all residents in Texas who are infected with, have been exposed to, or are at risk for these diseases. In fiscal year 2012, 1,297 newly identified persons with active TB and 11 newly identified persons with Hansen's disease received public health services.

**Zoonosis Control**

The Zoonosis Control Program affects everyone, since anyone may contract a zoonotic disease regardless of age, gender, nationality, or race. Additionally, the program more directly affects the following groups.

- Rule requirements and course approval procedures affect shelter personnel tasked with animal euthanasia, and sponsors that provide euthanasia training.

- Caging and registration requirements affect owners of dangerous wild animals.
- Requirements for signage with the public health warning concerning salmonella risk affect pet storeowners selling reptiles.
- Requirements for mandatory training affect ACOs, and requirements for sponsor and course approval affect sponsors of ACO training.
- The disease investigation process affects those diagnosed with reportable zoonotic diseases.
- The risk assessment and distribution of rabies biologicals affect those potentially exposed to rabies.
- Rule requirements, risk assessment, and consultation on treatment protocols affect owners of domestic animals potentially exposed to rabies.
- The application and selection process and the level of available funding affect applicants for Animal Friendly grants and the potential clients of the applicants.
- The program specifically affects residents of 69 counties where DSHS distributes rabies vaccine bait to coyote and gray fox populations, reducing the exposure of humans and domestic animals to wildlife rabies. The program indirectly affects all Texas residents, because rabies has not spread as it did previously in the original epizootic outbreak zone.

**Emerging and Acute Infectious Disease**

The program activities protect all Texans from infectious diseases. There are no qualifications or eligibility requirements. Because of underlying medical conditions, lifestyles, or behavioral factors, some Texans may be at more risk for certain infections than other individuals.

**Immunization Program**

The Immunization Program serves an estimated 4,451,903 children who are eligible for the TVFC Program in Texas. These children meet one of the following eligibility criteria: Medicaid, Children's Health Insurance Program (CHIP), American Indian/Alaskan Native, uninsured, or underinsured. The program provides vaccines for these children and educates the children and their families, healthcare providers, and the public about the importance of immunizations.

Approximately 1,859,842 other children are considered insured and do not qualify for the TVFC Program; however, DSHS plays a leadership role in ensuring providers who serve these children, as well as parents and families, are educated regarding the importance of receiving immunizations on time and in accordance with the United States recommended immunization schedule. The educational information also incorporates appropriate messages for adult immunizations.

Texas is now within reach of the Healthy People 2020 goals for childhood immunization coverage levels; therefore, the Immunization Program is turning attention toward improving coverage levels for adult populations. The availability of new vaccines in recent years has also contributed to a shift from what was largely a childhood immunization program to focus more on vaccinating adolescents and adults. Because of these changing dynamics, central office and

regional staff provide ongoing program activities to include adult and adolescent perspectives, and work with stakeholders and healthcare providers who care for older children and adults.

Funding is limited for adult vaccines, but the Immunization Program provides for all Texans. DSHS expanded the Texas adult vaccine safety net program in 2007 to include all routinely recommended vaccines. The program assesses immunization needs for adults who seek other services through public health departments and provides those immunizations, if the patient wishes. In 2008, supplemental funding through the federal immunization grant provided funds for the hepatitis B vaccine. The funding allowed for administration of the vaccine to high-risk and underinsured adults through federally qualified health centers and family planning clinics. Funding through the American Recovery and Reinvestment Act of 2009 allowed further expansion of all routinely recommended vaccines to these entities as well. Although no money remains in these funding streams, DSHS has determined that funding is sufficient to continue providing vaccines for adults to all provider types currently enrolled. DSHS is no longer recruiting eligible clinics, since funding is not sufficient for expansion. Currently, the Immunization Program has 482 adult clinic sites actively participating in the adult vaccine safety net program.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The DCP Services Division administers the Infectious Disease Program.

The Infectious Disease Prevention Section, TB/HIV/STD Unit includes two branches with HIV/STD responsibilities (the HIV/STD Prevention and Care Branch and the TB/HIV/STD Epidemiology and Surveillance Branch), and two branches with TB responsibilities (the TB Services Branch and the TB/HIV/STD Epidemiology and Surveillance Branch). The TB Services Branch administers several other programs as well.

The Infectious Disease Prevention Section, Infectious Disease Control Unit, Zoonosis Control Branch office in Austin and Zoonosis Control Programs in each of the eight DSHS health service regions (HSRs) administer the Zoonosis Control Program. Regional Zoonosis Control Programs and staff are under the control of the HSR with funding and support from Zoonosis Control Branch.

The Infectious Disease Prevention Section, Infectious Disease Control Unit, Emerging and Acute Infectious Disease Branch performs infectious disease surveillance and response activities. The branch is composed of two groups and two teams: Data and Prevention Group, Epidemiology and Surveillance Group, healthcare-associated infections team, and the surveillance system team.

The Infectious Disease Prevention Section, Immunization Branch administers the Immunization Program. The Immunization Branch consists of five major program areas: Operations Group; Assessment, Compliance, and Evaluation Group; Public Information, Education, and Training Group; ImmTrac Group (immunization registry); and Vaccine Services Group. DSHS also has approximately 200 full-time equivalent positions across the state in the HSRs. Currently, 50 LHDs contract with the Immunization Branch to enhance the delivery of immunization services at the local level. Additionally, the Infectious Disease Prevention Section, Infectious Disease Control Unit, and Emerging and Acute Infectious Disease Branch conduct disease surveillance activities for vaccine-preventable diseases. The Immunization Branch conducts activities related to perinatal hepatitis B prevention.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/pps.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $147,517,796 |
| General Revenue | $108,679,834 |
| General Revenue-Dedicated | $411,719 |
| Other | $38,334,420 |

The Immunization Program uses a funding formula to allocate $15.6 million to LHDs to ensure continuity of immunization services at the local level. The funding formula takes into account the number of TVFC providers in the county and the county population density for ages 0-18. The Immunization Program has maintained level funding for the 50 LHD contracts.

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| DSHS Community Mental Health and Substance Abuse Services | These services provide HIV testing and counseling and provision of case management services to HIV-positive persons actively using and in recovery from substance abuse. | These services focus specifically on the substance-using population. |

| Name | Similarities | Differences |
|---|---|---|
| HSRs | Each region conducts activities related to the federal immunization grant with oversight from the Austin office. | The Austin office does not conduct service delivery activities. HSRs operate clinics that vaccinate clients. |

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Ryan White Program Part A Grantees | This program provides medically related and critical support services for persons with HIV/ AIDS in specifically defined Eligible Metropolitan Areas (EMA) and Transitional Grant Areas (TGA). Funds flow directly from the U.S. Health Resources and Services Administration (HRSA) to the EMA and TGA. | Part A is not statewide. These funds complement funds DSHS provides to communities for HIV-related medical care. Local plans for use of DSHS funds must take into account services available through Part A funds. DSHS provides support for services inside the EMA/TGA and throughout the rest of the state. |
| Ryan White Program Part C Grantees | This program provides medical services to persons with HIV. These funds flow directly from HRSA to the clinics. | The program awards Part C funds to individual clinics on a competitive basis. Funds are not statewide. These funds complement funds DSHS provides to communities for HIV-related medical care. Local plans for use of DSHS funds must take into account resources available through Part C funds. |
| Ryan White Program Part D | This program provides medical services to women and children with HIV/AIDS served by specific clinics. These funds flow directly from HRSA to the clinics. | The program awards Part D funds to individual clinics on a competitive basis. Funds are not statewide. These funds complement funds DSHS provides to communities for HIV-related medical care. Local plans for use of DSHS funds must take into account resources available through Part D funds. DSHS provides services to women and children, regardless of location. |

| Name | Similarities | Differences |
|---|---|---|
| City of Houston | The City of Houston receives direct funds from the CDC to provide HIV prevention and surveillance services. | The service area is limited to Houston and the surrounding area. DSHS provides HIV and STD prevention services and surveillance across the state. |
| Community-based organizations directly funded by CDC | These organizations provide evidence-based HIV prevention interventions. | CDC funds these organizations to deliver a specific intervention and services are not statewide. DSHS provides HIV prevention services across the state. |
| Texas Department of Housing and Community Affairs<br><br>Local housing authorities | These housing authorities provide Section 8 rental assistance vouchers to eligible clients. | Section 8 focuses on the general low-income population and generally has long waiting lists. DSHS Housing Opportunities for Persons with AIDS Program provides rental and utility assistance specifically to low-income persons with HIV/AIDS. |
| Texas Animal Control Association (TACA) | Both DSHS and TACA provide educational opportunities for ACOs. | DSHS provides training according to Chapter 829, Texas Health and Safety Code. |
| LHDs | LHDs conduct infectious disease surveillance and healthcare services to their respective constituents. LHDs also conduct activities related to the federal immunization grant with oversight from the Austin office. | LDHs are responsible for their specific local jurisdiction whereas DSHS has statewide responsibility. The Austin office does not conduct service delivery activities. LHDs operate clinics that vaccinate clients. |
| Health and Human Services Commission (HHSC), Immigrant and Refugee Affairs Program | The Immigrant and Refugee Affairs Program provides technical assistance and consultation and oversees and provides funding for refugee resettlement activities in Texas. | The Immigrant and Refugee Affairs Program provides funding for refugee health assessments via interagency contract, obligating Office of Refugee Resettlement funds. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

**HIV Medications Program and HIV Care**

DSHS receives Ryan White Part B funds for HIV medications and HIV care and treatment. DSHS carries out coordinated planning and program implementation with Ryan White Program Part A, C, and D recipients, meeting on a regular basis both locally and at the state level with the grantees who receive this funding. At a local level, planned activities and program goals supported with DSHS funds (Part B and General Revenue) are set after consultation with other Ryan White grantees to eliminate duplication of services. DSHS provides grantees of all Ryan White Parts access to the DSHS client level data system free of charge to promote efficient and effective data collection, which in turn promotes solid, coordinated care plans for clients and information for comprehensive planning across funding sources. DSHS also develops the Statewide Coordinated Statement of Need, a consensus document that is the product of consultation across the titles that highlights cross cutting issues affecting all Ryan White programs in Texas.

In the prevention arena, DSHS consults frequently with the City of Houston. In addition, DSHS encourages providers funded by CDC and by the Substance Abuse Mental Health Services Administration to participate in Texas' HIV/STD prevention planning process. DSHS also compiles a resource inventory of funded prevention interventions to guard against funding duplicative programs. The City of Houston performs surveillance only for its local area and enters data into the state registry.

Internally, the DCP Services Division, HIV/STD Program coordinates with the Mental Health and Substance Abuse Services Division, HIV Program via cross unit meetings on specific topics. The programs also work together on special projects.

**Zoonosis Control**

Chapter 829, Texas Health and Safety Code, mandates the training provided by Zoonosis Control. TACA, plus a plethora of outside sponsors statewide and from other states, provides various training opportunities that, if approved by the Zoonosis Control Branch, can satisfy ACOs' statutory training requirements. Students are free to choose the opportunities that best fit their needs.

The Texas Veterinary Medical Diagnostic Laboratory, Texas Animal Health Commission, and DSHS have a memorandum of understanding that addresses zoonotic disease reporting and coordination.

**Immunization Program**

The Immunizations Program convenes and coordinates activities by participation in TISWG meetings. This group is comprised of internal and external stakeholders who meet quarterly to provide a forum for diverse partners in the state immunization system to share ideas, perspectives, best practices, and resources to target more effectively efforts to raise vaccine coverage levels in Texas. Routine collaborations with Texas Health Steps, Medicaid, and CHIP occur as business needs arise. The Immunization Branch meets with HSR program managers as

needed to discuss immunization issues. The contracts with 50 LHDs also ensure continuity of services and activities across the state.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| LHDs | LHDs are public health agencies operated by counties and/or cities. They provide healthcare and diagnostic services, including treatment, case management, and contact investigations and conduct disease surveillance. | DSHS contracts and sub-contracts with a number of LHDs for the provision of HIV/ STD surveillance, services, and prevention. LHDs receive funding from DSHS to deliver public health services and conduct disease surveillance specific to TB, Hansen's disease, refugee health screenings, and perinatal hepatitis B prevention. They work in partnership with DSHS in disease surveillance, prevention, and control activities, as well as in infectious disease surveillance, prevention, and control activities. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| CDC | CDC administers HIV/STD prevention and surveillance funding and provides a national framework and funding for TB prevention and control activities. Additionally, CDC participates in setting national refugee health screening guidelines. CDC provides information to enhance health decisions and promotes health through partnerships with state health departments and other organizations. | CDC provides funding and guidance for DSHS HIV and STD prevention and surveillance activities. CDC provides funding for TB services and works in partnership in disease surveillance, prevention, and control activities. The Refugee Health Screening Program incorporates CDC screening guidelines as part of the overall screening requirements for eligible clients. DSHS and CDC work in partnership in infectious disease surveillance, prevention, and control activities. DSHS contracts with the CDC to administer the Immunization Program. |
| HRSA | HRSA administers the Ryan White Program, which provides funding for | HRSA provides funding and guidance for the DSHS AIDS Drug Assistance Program and HIV services programming that |

| Name | Description | Relationship to DSHS |
|---|---|---|
| | treatment and support services. | includes outpatient medical care and critical support services. |
| Housing and Urban Development (HUD) | HUD administers the Housing Opportunities for People with AIDS (HOPWA). | HUD provides funding and guidance to the DSHS HOPWA Program for rent and utility assistance to prevent homelessness of persons with HIV/AIDS. |
| U.S. Department of Health And Human Services (DHHS), Office of Refugee Resettlement | The Office of Refugee Resettlement administers the national refugee resettlement program. | The Office of Refugee Resettlement provides funding for DSHS refugee health assessments. |
| DHHS, National Hansen's Disease Program | The National Hansen's Disease Program provides directives for administering Hansen's disease services. | The National Hansen's Disease Program provides funding for DSHS Hansen's disease services. |
| USDA, Animal Plant Health and Inspection Services (APHIS) Wildlife Services | APHIS Wildlife Services includes the management of the National Rabies Program. | APHIS Wildlife Services assists DSHS with implementation of the ORVP and provides oral rabies vaccine bait for the gray fox project in West-Central Texas. |
| Texas National Guard | The Texas National Guard is a component of the U.S. military complex. | The Texas National Guard assists DSHS with implementation of the ORVP when approved by the Governor's office. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

Contracts established in this program focus on prevention and control of infectious diseases and their complications. DSHS establishes contracts to handle the following activities:

- HIV, STD, TB, and Hansen's disease;
- HIV and STD surveillance;
- medication to people with AIDS;

- HIV medications through Texas HIV Medication Program;
- refugee health;
- viral hepatitis;
- activities for detection, prevention, and control of other infectious diseases;
- immunization programs for children and adults;
- quality assurance activities for immunization services;
- influenza incidence surveillance and real-time polymerase chain reaction method for typing influenza viruses;
- surveillance activities for arboviruses;
- prevention of healthcare associated infections; and
- sterilization of dogs and cats owned by public.

Amount of contracted expenditures in fiscal year 2012: $102,216,911
Number of program contracts: 1,053 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $3,508,715.54 | Houston Regional HIV/AIDS Resource Group | Improve access to health and support services for people with HIV/AIDS |
| $2,497,054.16 | Houston Regional HIV/AIDS Resource Group | Improve access to health and support services for people with HIV/AIDS (additional contract) |
| $1,777,895.27 | Dallas County | Prevent and control the Transmission of vaccine-preventable disease |
| $1,544,380.13 | Houston Regional HIV/AIDS Resource Group | Outpatient health and support services for individuals with HIV/AIDS |
| $1,466,729.39 | Dallas County | Improve access to health and support services for people with HIV/AIDS |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor

information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

DSHS awards grants in this program for the following services:

- HIV, STD, TB, and Hansen's disease;
- HIV and STD surveillance;
- medication to people with AIDS;
- HIV medications through Texas HIV Medication Program;
- refugee health;
- viral hepatitis;
- activities for detection, prevention, and control of other infectious diseases;
- immunization programs for children and adults;
- quality assurance activities for immunization services;
- influenza incidence surveillance and real-time polymerase chain reaction method for typing influenza viruses;
- surveillance activities for rotavirus infection and immunization;
- surveillance activities for arboviruses;
- prevention of healthcare associated infections; and
- sterilization of dogs and cats owned by public.

Using sub-recipient contracts, the program awards grants in the following manner:

- through competitive solicitations;
- without competitive solicitation (not required when amount is under $5,000);
- on an emergency or sole source basis when an approved emergency or sole source justification waives competition; and
- to a state or local governmental entity through direct negotiation and grant contract execution (these entities are exempt from competition).

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory changes to assist the program in performing its functions.

**Chapter 2152, Texas Occupations Code –** DSHS recommends revision to remove DSHS' role in licensing and inspection of circuses, carnivals, and zoos. Since the statute became effective in 1981, DSHS has not issued any permits because circuses, carnivals, and zoos with a federal permit are exempt from the state license requirement. Federal permits issued by the USDA are

required for most of these entities, are more economical to obtain, and can be used in lieu of the state permit. DSHS should be relieved of responsibility in the statute pertaining to the issuance of licenses and inspection of circuses, carnivals, and zoos. However, the law is still of value to have in place to ensure compliance with the minimum standards and to provide enforcement capabilities for local animal control and law enforcement officers when necessary.

**Chapter 89, Texas Health and Safety Code** – The Historical and Statutory Notes section of this chapter describes a cost allocation formula between DSHS, the Texas Department of Criminal Justice, and counties for TB screening and testing in jails and community correction facilities. The notes excuse a county from responsibilities if the other responsible parties do not follow the formula. Senate Bill 57, 73rd Legislature, Regular Session, 1993, established the funding formula in the Historical and Statutory Notes section. DSHS has been unable to comply with the funding requirement that, if implemented, would be a substantial cost to the agency.

**Chapter 98, Texas Health and Safety Code** – DSHS recommends revision to this statute to add preventable adverse events reporting as the events are phased in.

**Chapter 161, Texas Health and Safety Code** – DSHS recommends revision to clarify language regarding the statewide immunization registry, ImmTrac, including the definition of a disaster, a conflict in language regarding the reporting of adverse events, and inconsistencies about release of registry data.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

The Legislature has given DSHS and HHSC the authority to establish immunization requirements for children attending secondary schools. The Department of Family and Protective Services (DFPS) has the authority to establish requirements for children in childcare facilities. DFPS and DSHS work very closely to audit childcare facilities annually and provide education when a facility is not adequately enforcing the immunization requirements. DSHS coordinates with the

Texas Education Agency in working with schools. DSHS monitors schools and childcare facilities for compliance and provides technical assistance when deficiencies are identified.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Health Promotion and Chronic Disease Prevention |
| **Location/Division** | 1100 W. 49th Street, Austin - Disease Control and Prevention Services (DCP) Services Division |
| **Contact Name** | Janna Zumbrun, Assistant Commissioner, DCP Services Division |
| **Actual Expenditures, FY 2012** | $25,494,576 |
| **Number of Actual FTEs as of June 1, 2013** | 53.4 |
| **Statutory Citation for Program** | Chapter 161, Subchapter A, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Health Promotion and Chronic Disease Prevention Programs have the following primary objectives.

- Reduce the prevalence of preventable chronic diseases and injury.
- Administer abstinence education programs.
- Administer service care programs related to certain chronic health conditions.

Major activities include the following.

**Abstinence Education Program**

The Abstinence Education Program provides abstinence education for youth grades 5-12 to delay initiation of sexual activity, as part of a continuum of services to decrease the teen birth rate and rate of sexually transmitted infections in youth ages 15-19. DSHS direct service contracts provide both in-school/school-based and after school/community-based programming. Additionally, DSHS uses some abstinence funding to develop and distribute statewide resources. School districts, community organizations, youth, and parents can access these resources via websites, toolkits, and booklets/DVDs.

**Alzheimer's Program and Council**

The Alzheimer's Program and Council disseminate information on services and related activities for persons with Alzheimer's disease and related disorders to the medical and academic communities, caregivers, associations, and the public. The program coordinates services and activities of state agencies, associations, and other service providers. The program also coordinates statewide planning to address the burden of Alzheimer's disease. In addition, the program supports the Texas Council on Alzheimer's Disease and Related Disorders, which

recommends actions and policies for the benefit of persons with Alzheimer's disease and related disorders and their caregivers, and supports statewide coordinated research. The program develops and maintains statewide partnerships and conducts surveillance on the prevalence and burden of Alzheimer's disease.

**Asthma Prevention and Control**

Staff promotes the prevention and control of asthma through the implementation of evidence-based programs and clinical treatment standards in healthcare, worksite, and community settings. Additionally, staff encourages local communities to become involved in asthma prevention and control. To address the social and economic burden of asthma in Texas, the Texas Asthma Coalition Program (TACP) provides data, educational materials, and other resources for asthma stakeholders, including healthcare professionals, community and faith-based organizations, schools, and the public on asthma control and management. In addition, TACP conducts ongoing surveillance on the prevalence and burden of asthma in Texas. TACP surveillance data raises awareness about the effect of asthma on the health of the community. Accordingly, TACP develops and maintains a report on the burden of asthma in Texas with the most current report published in Summer 2011, entitled *The 2010 Asthma Burden Report*.

**Cardiovascular Health and Wellness (CHW) Program**

The CHW Program coordinates a statewide partnership to implement strategies from the Texas Plan to Reduce Cardiovascular Disease and Stroke. Approximately 80 partners from around Texas are participating on four committees that reflect the goals of the state plan.

The CHW Program conducts surveillance activities using available data sets related to prevalence, mortality, hospitalization rates, cost of care, and quality of care indicators. The program provides a burden report and numerous regional and local reports for public and private stakeholders to use. Program staff works with statewide and agency partners to expand high quality stroke care to all Texans, including protocols for rapid transport of stroke victims to stroke-certified facilities, and public education about stroke signs and symptoms and calling 911.

The CHW Program works with the cities of San Antonio and Austin to implement value-based benefits design among a group of 10 employers, 6 of which have over 2,000 employees each. Value-based benefits use incentives to increase employee participation in provided medications and health promotion services that prevent and control risk factors for cardiovascular disease and stroke.

**Chronic Kidney Disease (CKD) Program**

The CKD Program collaborates with national, state, and community organizations to provide education and outreach regarding CKD. The program develops, implements, and evaluates a social marketing campaign (Love Your Kidneys/Save Their Kidneys). The program provides programmatic oversight to the CKD study, which the Texas Tech University Health Sciences Center is conducting. Finally, the program provides staff support for the CKD Task Force.

**Diabetes Control Program**
The Diabetes Control Program coordinates statewide diabetes prevention and control efforts, and builds expertise in program, science, and policy to prevent and control diabetes. The program expands systems to define and analyze the scope of the diabetes problem, improves access to diabetes care for all people, and raises the quality of that care. Additionally, the program uses statewide public health projects to reduce diabetes-related problems and to inform, educate, and empower external supporters to prevent and control diabetes. Program staff supports the activities of the Texas Diabetes Council.

**Safe Riders**
The Safe Riders Program serves as the lead child passenger safety program for Texas. The program distributes car seats for infants and children of low-income families. The program also provides information about car seats to the public and conducts child seat check-up events and national child passenger safety technician training courses.

**Texas Comprehensive Cancer Control Program (TCCCP)**
TCCCP promotes the implementation of policies, programs, and healthcare system improvements identified as high priorities in the Texas Cancer Plan. TCCCP develops local coalitions to implement comprehensive cancer control programs that include education. TCCCP facilitates the Cancer Alliance of Texas (CAT), a statewide coalition that includes consumers and representatives of public and private educational, treatment, research, and patient support organizations.

**Worksite Wellness Program**
The Worksite Wellness Program develops and disseminates a model worksite wellness program for state agencies as required by Chapter 664, Texas Government Code, and provides guidance and technical assistance to state agencies as they implement worksite wellness programs. Program staff supports the Worksite Wellness Advisory Board.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

Health Promotion and Chronic Disease Prevention programs ensure effectiveness by promoting and implementing proven, evidence-based strategies and initiatives that the Centers for Disease Control and Prevention (CDC) and other federal funding agencies have approved. The following are examples of the methods used in some of the individual areas.

**Abstinence Education Program**
The Abstinence Education Program encourages contract applicants to use effective interventions for reducing teen pregnancy, including evidence-based programs defined by the Administration of Children and Families as programs that have demonstrated impacts on sexual activity (including delaying initiation of sexual activity), contraceptive use, sexually transmitted

diseases and infections, and pregnancy or births. DSHS provides a menu of evidence-based curricula from which to choose.

Applicants may choose other curricula not on the DSHS menu of curricula with the submission of an evaluation study published in a peer-review journal. The study must demonstrate that the chosen curricula impacts students' thoughts or actions to delay or decrease sexual activity. Any curriculum chosen must be age appropriate and medically accurate. Staff evaluates curricula chosen off the menu on a case-by-case basis during the competitive procurement process.

**Asthma Prevention and Control Program**

The Asthma Prevention and Control Program works with local organizations to promote evidence-based clinical care guidelines for the treatment of asthma in medical settings and the care of students with asthma in schools. The Texas Asthma Coalition Program has completed the first year of a five-year cooperative agreement that has performance measure reporting as a component of the agreement.

**Cardiovascular Health and Wellness Program**

The CHW Program works with communities to implement evidence-based policies, which improve health behaviors and lead to a reduction in heart disease, such as implementing worksite wellness programs that include physical activity, nutrition education, and smoking cessation.

**Chronic Kidney Disease Program**

The CKD Program provides educational services designed to increase awareness, diagnosis, and treatment of CKD through outreach to individuals with diabetes mellitus, and/or a family history of kidney disease, and education to physicians about appropriate screening and treatment for individuals at risk for end stage renal disease (ESRD). The key component of the program is a comprehensive media campaign that targets areas of the state with a disproportionate burden of ESRD and contributing risk factors. A survey of community-based diabetes programs showed that almost half of the survey participants had seen or heard the public service announcements. Almost all reported at least one change in awareness of risk factors, knowledge of kidney disease, or behaviors.

**Diabetes Program**

The Texas Diabetes Program implements CDC-approved, evidence-based strategies that include funding of community-based education programs to help individuals with diabetes control their blood glucose. The program reports these activities electronically via the Program Management and Tracking System. The program also promotes the use of clinical care guidelines in the medical setting that have been effective in treating and controlling diabetes, as well as preventing complications, such as heart disease, kidney disease, amputations, and blindness. Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS measures assess performance of health maintenance organizations

(HMOs) on diabetes indicators, comparing Texas performance with the nation. Basic service HMOs with 5,000 or more members must report HEDIS measures annually to the Texas Health Care Information Collection at DSHS. The Texas Diabetes Program also promotes the use of clinical care guidelines in the medical setting that have been proven effective in the treatment and control of diabetes and in the prevention of complications such as heart disease, amputations, and blindness.

In fiscal year 2012, the Texas Diabetes Program had 61,657 client encounters. This number is derived from the number of clients (persons with or at risk for diabetes) receiving educational services through one-on-one, group, and community outreach and the number of healthcare professionals receiving education.

**Safe Riders Program**
The Safe Rider Program inspects the installation of infant car seats and makes car seats available to low income families because car seats, if properly installed, prevent injuries and save lives.

**Texas Comprehensive Cancer Control Program**
TCCCP coordinates the CAT and facilitates the development of local coalitions that implement evidence-based strategies in areas identified as high priorities in the Texas Cancer Plan.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**2001** – Legacy Texas Department of Health (TDH) receives a grant from CDC to develop a state-level asthma program. The program grows from its initial purpose as the main programmatic arm for asthma initiatives in the state to its current role as a sustainable, public health asthma program within a public health agency.

**2006** – The CAT collaborates with the Texas Cancer Registry in its successful efforts to achieve Gold level certification from the North American Association of Central Cancer Registries.

**2007** – A CAT ad hoc committee provides technical assistance to the group sponsoring the legislation that created the Cancer Prevention and Research Institute of Texas (CPRIT). CPRIT fosters cancer research and prevention by providing financial support for a wide variety of projects relevant to cancer research and prevention.

**2009-2010** – The DSHS Alzheimer's Disease Program and Alzheimer's Council begins formal discussions around development of the first, coordinated Texas State Plan on Alzheimer's Disease. During 2009 and 2010, DSHS forms a State Plan Steering Committee, and recruits more than 120 partners. The Committee identifies goals, and develops and implements the plan in 2010.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

The Health Promotion and Chronic Disease Prevention programs work through state and local health organizations, coalitions, and agencies to prevent or control chronic disease and reduce injuries by changing community-based policies, implementing quality systems of medical care, training health professionals, increasing public awareness, conducting educational classes, and monitoring trends in the prevalence of chronic disease. These activities affect the population at large.

**Abstinence Education**

Abstinence education direct service contracts focus on youth in grades 5-12 with priority consideration for counties that have a birth rate that is equal to or exceeds 42 per 1,000 for females ages 15-19, and that have had at a least 250 births within that county. Contract categories have the following further eligibility requirements.

- In-school intervention – Elementary, middle, and high school sites serving grades 5-12 that have 56-100 percent of students living in poverty (as defined by the Texas Education Agency).
- After school intervention – To be implemented in after-school or other community settings with a focus on high-risk youth such as youth in the child welfare system or foster care.

Any Texan can access statewide resources targeting school districts, community organizations, youth, and parents.

**Alzheimer's Program**

The Alzheimer's Program provides education, information, and referral to persons with Alzheimer's disease, their caregivers and care providers, and to other statewide organizations. The Alzheimer's Disease Program has developed a partnership of over 120 members comprised of individuals with diverse backgrounds from state, local, and community level organizations; academic and research institutions; for-profit and nonprofit sectors; businesses; healthcare sector; and family members of individuals afflicted with Alzheimer's disease, who are committed to working with the program to address the burden of Alzheimer's disease in Texas.

**Asthma Prevention and Control**

The Asthma Prevention and Control Program has developed partnerships comprised of individuals with diverse backgrounds from state, local, and community level organizations; academic and research institutions; for-profit and nonprofit sectors; businesses; healthcare sector; and family members of individuals afflicted with asthma, who are committed to working with the program to address the burden of asthma in Texas. The Texas Asthma Coalition activities affect adults and children with asthma and their caregivers through the provision of asthma management and control educational activities. These activities include providing adults and healthcare providers with asthma-related continuing medical education.

**Cardiovascular Health and Wellness Program**
As a statewide program that works on policy, system, and environmental strategies to prevent and control cardiovascular diseases and stroke, the CHW Program affects nearly all Texans.

**Chronic Kidney Disease Program**
The CKD Program implements an ESRD campaign that targets areas of the state with a disproportionate burden of ESRD. The program focuses on individuals with diabetes mellitus and/or a family history of kidney disease and provides education to physicians about appropriate screening and treatment for individuals at risk for ESRD. The CKD Program also works through a state university to conduct a study to determine the prevalence of CKD in Texas. In addition, the CKD Program educates healthcare professionals on early screening, diagnosis, and treatment of CKD; complications related to CKD; and advantages of ESRD modality education and early renal replacement therapy.

**Diabetes Program**
The Diabetes Program works through state and local health organizations and agencies to prevent or control diabetes through community-based policies, environmental changes, implementation of quality systems of medical care, training for health professionals, increased public awareness, educational classes, and monitoring trends in the prevalence of diabetes. During fiscal year 2012, the program's community diabetes projects assisted 1,183 persons with diabetes or at risk for diabetes through nutrition classes; 1,282 persons through physical activity classes; and 1,254 persons through diabetes self-management education classes. Projects conducted outreach and education activities involving 1,370 healthcare providers in Texas.

Community-based diabetes education classes target all persons with type 1 or type 2 diabetes or at risk of developing type 2 diabetes, with special attention to high-risk populations.

**Safe Riders**
Within the Safe Riders Program, the target audiences are the parents and caregivers of children under age 15. The distribution of child safety seats is limited to persons with low-incomes (self-certified), one seat per family, and the parent/caregiver must attend a one-hour class about child passenger safety.

**Texas Comprehensive Cancer Control Program**
There are three components within TCCCP. The Statewide Alliance Component provides administrative support and coordination to the CAT. CAT engages organizations, agencies, institutions, and individuals to work collaboratively to reduce the impact of cancer in Texas and promote the Texas Cancer Plan. The Regional Coalition Component disseminates the concepts of comprehensive cancer control to local communities and assists communities with local implementation of the Texas Cancer Plan. Currently, TCCCP staff in Amarillo, Del Rio, Tyler, and Wichita Falls support community coalitions. The third component provides prostate cancer and ovarian cancer prevention activities.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The DCP Services Division, Health Promotion and Chronic Disease Prevention Section administers all Health Promotion and Chronic Disease Prevention programs. The Health Promotion and Chronic Disease Medical Director provides medical direction.

Health Promotion and Chronic Disease Prevention programs work directly with state, regional, and local public health agencies, governmental agencies, nonprofit and for-profit organizations, and volunteer groups to identify available resources and gaps in services to prevent and treat the respective chronic conditions. Most programs contract or form partnerships with organizations and agencies to expand their reach through training, patient education, distribution of resources, data collection, and policy assessment and development. Several programs provide support for legislatively mandated advisory councils, which assist DSHS in setting goals and objectives. Examples of these councils include the Texas Diabetes Council, Texas Council on Cardiovascular Disease and Stroke, Texas Arthritis Advisory Committee, Worksite Wellness Advisory Board, Texas School Health Advisory Committee, and Texas Council on Alzheimer's Disease and Related Disorders. The TCCCP supports a statewide coalition of partners who help implement the Texas Cancer Plan.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/pps.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $20,254,621 |
| General Revenue | $5,131,425 |
| General Revenue-Dedicated | $250 |
| Other | $108,280 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| DSHS Cardiovascular Disease Program, Diabetes Program, and Obesity Program | The Asthma Prevention and Control Program is similar to these programs in that the diseases share some common modifiable risk factors. | Asthma has significantly greater immediate environmental causes than those of other diseases. Disease management strategies are different from asthma for each of these other diseases. |

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| Texas Cooperative Extension Rural Passenger Safety | This program provides from two to three child passenger seat training workshops per year, child seat checkups, and a limited number of child seats via those events. | This program concentrates on providing child passenger seat services to rural areas of Texas. Safe Riders program is larger in scope, with a systematic seat distribution program, and covers urban areas. |
| Safe Kids Coalitions | These coalitions provide child seat checkups and a limited number of child seats via those events. | The coalitions do not have any systematic seat distribution program like the Safe Riders program. |
| Safe Communities Grantees | These grantees provide child passenger seat services in specific areas, such as Waco and El Paso. | Unlike Safe Riders, the grantees do not have any systematic seat distribution programs, do not conduct child passenger seat training courses, and provide only limited educational and leadership services. |
| Department of Assistive and Rehabilitative Services, Division for Blind Services (DBS), Blindness Education, Screening, and Treatment (BEST) Program | Like the Diabetic Eye Disease Program, the BEST Program assists uninsured adult Texas residents with payment for urgently needed eye-medical treatment. | In addition to diabetic retinopathy, the BEST Program serves qualified individuals with glaucoma, detached retina, or any other eye disease determined to be an urgent medical necessity by both the applicant's eye doctor and the DBS ophthalmologic consultant or designee. BEST Program is funded with voluntary donations when Texans renew their driver's licenses or Department of Public Safety-issued identification cards. |

| Name | Similarities | Differences |
|---|---|---|
| Alzheimer's Associations | Both Alzheimer's Associations and the Alzheimer's Program provide information and support to patients with Alzheimer's disease, their families, and long-term care providers. They co-lead in State Plan development and implementation. | Alzheimer's Associations are nonprofit agencies. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

The Texas Department of Transportation (TxDOT) funds Safe Riders, Texas Cooperative Extension Rural Passenger Safety, and Safe Communities. TxDOT determines the specific grant objectives for the programs and ensures that the programs complement each other rather than duplicate work.

The DSHS Texas Asthma Control Program partners with local asthma coalitions and other stakeholders for statewide planning and implementation.

The DSHS Alzheimer's Disease Program partners with the Alzheimer's Disease Association in Texas for statewide planning and implementation. The Alzheimer's Disease Program Coordinator is a standing member of the Texas Department of Public Safety, Division of Emergency Management, State AMBER/Blue/Silver Alert Committee and the Texas Department of Aging and Disability Services, Texas Healthy Lifestyles Program and Aging Texas Well Advisory Committee. Through these meetings, programs are able to share information and to identify ways to collaborate and enhance services. Staff report program activities quarterly. DSHS remains the lead agency in Texas on Alzheimer's disease statewide planning.

Within the Abstinence Education Program, school districts or communities may use toolkits as a stand-alone curriculum, if they have no abstinence programming, or they can use them to supplement existing abstinence programming. The educational information provided in the toolkit reinforces the Texas Essential Knowledge and Skills for Health Education for elementary and middle school students by providing a variety of interactive learning techniques to enhance retention of abstinence information.

A cooperative agreement from the CDC funds the TCCCP to fulfill specific functions. As such, there is no duplication. Likewise, the Asthma Control and Prevention Program is the only Health and Human Services System program that coordinates and directs statewide planning

and coordination of asthma strategies and initiatives. Other state and local agencies are involved in providing direct care services to those with asthma, but none coordinates and implements statewide planning to address the burden of asthma in Texas.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| City and county governmental agencies | These entities may be local health departments (LHDs), city management, parks and recreation, police departments, emergency medical services, neighborhood centers, cooperative extension, public hospitals, and social service agencies. | Their relationship with DSHS is contractual. DSHS coordinates service delivery, provides technical assistance, and assists in community assessments. The partnership focuses on common goals. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| CDC | CDC provides information to enhance health decisions and promotes health through partnerships with state health departments and other organizations. | CDC provides funding through cooperative agreements, guidance, and technical resources to programs to accomplish goals and objectives in health promotion and chronic disease prevention. |
| National Heart Disease and Stroke Prevention (NHDSP) Program, CDC. | The NHDSP Program shares program experiences and outcomes with state programs when requested. The NHDSP Program also contracts with LHDs to work within their communities to implement strategies that meet state plan objectives. | A cooperative agreement with the NHDSP Program funds the CHW Program. The NHDSP Program also provides technical assistance and support to the CHW Program. |
| National Highway Traffic Safety Administration (NHTSA) | NHTSA directs federal highway safety and consumer programs. | NHTSA provides funding for the Safe Riders Program via the TxDOT. |
| U.S. Environmental Protection Agency | EPA protects human health and the environment. | The Asthma Program has periodic communications with the EPA |

| Name | Description | Relationship to DSHS |
|---|---|---|
| (EPA) and its regional office | | due to the significant environmental causes of asthma, but does not receive any funding from the EPA. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

Contracts established in this program focus on the prevention and control of chronic diseases and their complications through a combination of primary and secondary population-based prevention efforts. DSHS established contracts that provide services in the following areas:

- diabetes,
- asthma,
- Alzheimer's disease,
- cardiovascular disease,
- obesity and nutrition,
- abstinence education,
- chronic disease transformation,
- prostate and ovarian cancer,
- school health, and
- Safe Riders.

Amount of contracted expenditures in fiscal year 2012: $14,980,628
Number of program contracts: 147 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $440,728 | University of North Texas Health Science Center | Evaluator for the Transforming Texas Program |
| $398,050 | Northeast Texas Public Health District | Transforming Texas: Healthy People in Healthy Communities Program |

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $345,850 | Seasons of Change, Inc. | Abstinence education after-school youth club intervention model |
| $307,264 | Williamson County and Cities Health District | Transforming Texas: Healthy People in Healthy Communities Program |
| $306,425 | The Institute of Public Health and Education | Transforming Texas: Healthy People in Healthy Communities Program |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

DSHS awards grants in this program to provide services in the following areas:

- diabetes,
- asthma,
- Alzheimer's disease,
- cardiovascular disease,
- obesity and nutrition,
- abstinence education,
- chronic disease transformation,
- health disparities,
- CAT website update,
- Texas Cancer Plan,
- prostate and ovarian cancer,
- school health, and
- Safe Riders.

Using sub-recipient contracts, the program awards grants in using the following methods:

- through competitive solicitations;
- without competitive solicitation (not required when amount is under $5,000);

- on an emergency or sole source basis when an approved emergency or sole source justification waives competition; and
- to a state or local governmental entity through direct negotiation and grant contract execution (these entities are exempt from competition).

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Laboratory Services |
| **Location/Division** | 1100 W. 49th Street, Austin - Disease Control and Prevention Services (DCP) Services Division |
| **Contact Name** | Janna Zumbrun, Assistant Commissioner, DCP Services Division |
| **Actual Expenditures, FY 2012** | $44,177,730 |
| **Number of Actual FTEs as of June 1, 2013** | 330.7 |
| **Statutory Citation for Program** | Chapter 73 and Section 12.0122, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Laboratory Services has the primary objective to provide analytical laboratory services in support of public health program activities, the Texas Center for Infectious Diseases, and the South Texas Health Care System. Major activities include the following.

**Newborn Screening**
The Newborn Screening Program tests all newborns for 29 disorders.

**Texas Health Steps Screening**
The Texas Health Steps Screening Program provides screening tests, such as blood lead, total hemoglobin, and sickle cell, for children enrolled in Texas Health Steps.

**Blood Lead Screening**
The Blood Lead Screening Program provides blood lead screening for the state.

**Safe Drinking Water**
The DSHS Safe Drinking Water Program provides analytical chemistry testing to support the Environmental Protection Agency Safe Drinking Water Program.

**Radiation Control**
The Radiation Control Program analyzes environmental samples from nuclear power plant sites and provides nuclear emergency response to these sites. Additionally, the Radiation Control Program analyzes surveillance samples from the Pantex Weapons Facility and environmental samples from other facilities, including manufacturers of radioactive sources, radio-pharmaceuticals, and tracer materials.

**Environmental Testing**
The Environmental Testing Program analyzes consumer products, indoor air samples, and environmental samples for contaminants.

**Meat Safety Testing**
The Meat Safety Testing Program analyzes meat products for selected constituents.

**Infectious Disease Testing**
The Infectious Disease Testing Program provides microbiological laboratory testing in bacteriology, mycology, mycobacteriology, parasitology, serology/immunology, virology, molecular biology, and entomology in support of DSHS programs.

**Clinical Testing**
Laboratory Services provides clinical testing in support of the Texas Center for Infectious Diseases and the outpatient clinic at the South Texas Health Care System.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

The key performance measures for Laboratory Services are the number of laboratory tests performed and the average cost per test ordered. The number of tests performed is a direct measure of the tests submitted to and tested by Laboratory Services. Other DSHS programs use data from these tests to identify and stop outbreaks, assure individuals receive appropriate medical care for identified infections or disorders, and identify and correct environmental issues. The Laboratory receives approximately 1.3 million specimens per year and performs approximately 1.9 million tests.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**1963** – Newborn Screening begins as a Phenylketonuria (PKU) pilot project. The Legislature mandates PKU screening in 1965.

**2001-2002** – Laboratory Services validates and implements methods for tuberculosis extended drug susceptibilities.

**2002** – Laboratory Services moves into a new laboratory building.

**2005** – Laboratory Services initiates the State of Texas' participation in National Genotyping Project with the Centers for Disease Control and Prevention (CDC).

**2005** – As a result of H.B. 790, DSHS expands the newborn screening panel from 7 to 27 disorders detectable by blood tests.

**2006** – Laboratory Services begins using the LabWorks laboratory information management system.

**2007** – Laboratory Services receives a Food Emergency Response Network grant, "Food Safety and Security Monitoring Project - Radiological Health." This grant provides funding for equipment, supplies, and training to enable the analyses of foods and food products in the event that additional laboratory surge capacity is needed for analyses related to radiological terrorism or other emergencies.

**2008** – Laboratory Services receives the U.S. Environmental Protection Agency (EPA) cooperative agreement, "Enhancing Capability and Capacity of Environmental Radiological Laboratories Across the Nation." The grant enables Laboratory Services to add equipment to improve the capacity for response in the event of a radiological or nuclear incident.

**2008** – DSHS upgrades the Laboratory Information System to include a module for electronically maintaining inventory and ordering supplies, instead of the previous paper system of handwritten orders and faxes.

**2009** – Laboratory Services receives National Environmental Laboratory Accreditation Conference full accreditation. Through exceptional item funding approved by the Legislature, DSHS adds cystic fibrosis to the newborn screening panel, bringing the total to 28.

**2009-2010** – Laboratory Services receives PulseNet certification for non-0157 E. coli and Vibrio species. PulseNet is a network of public health and food regulatory agencies designed to detect clusters of foodborne illness. Certification gives the DSHS Laboratory a direct link to the national database.

**2010** – Laboratory Services achieves College of American Pathologists accreditation. The federal government recognizes the College of American Pathologists Accreditation Program as being equal to or more stringent than the government's own inspection program.

**2011** – House Bill 411 changes the requirements for use and storage of newborn screening residual specimens from an "opt-out" to an "opt-in" system. Healthcare providers must give parents forms that disclose potential uses of the specimens. If a parent does not sign and submit the forms, DSHS may only use the child's specimen for specified limited purposes and must destroy the specimen within two years.

**2012** – Laboratory Services receives a five-year grant from the U.S. Food and Drug Administration (USDA) to assist with implementation and accreditation for food testing.

**2012** – DSHS adds severe combined immunodeficiency to the newborn screening panel, bringing the total to 29.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

Laboratory Services affect numerous programs throughout DSHS including the following:

- Infectious Disease Control Unit,
- Community Preparedness,
- Zoonosis Control,
- Immunization Branch,
- Tuberculosis (TB)/Human Immunodeficiency Virus (HIV)/Sexually Transmitted Diseases (STD) Unit,
- HIV/STD Comprehensive Services Branch,
- Refugee Health Screening Program,
- Product Safety Quality Assurance (QA) Unit - Milk Group,
- Product Safety QA Unit - Foods Group,
- Environmental and Consumer Safety Section,
- Meat Safety Assurance,
- Newborn Screening,
- Genetic Screening and Case Management,
- Texas Health Steps,
- Childhood Lead Poisoning Prevention Program,
- Women and Children's Health Services,
- Family Planning,
- Breast and Cervical Cancer Services,
- Rio Grande State Center/South Texas Health Care System,
- Texas Center for Infectious Diseases, and
- Radiation Safety Licensing.

Each of these programs determines qualifications or eligibility requirements for laboratory services.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The DCP Services Division, Laboratory Services Section provides analytical laboratory services at the Central Laboratory in Austin and the South Texas Laboratory, co-located with the Rio Grande State Center in Harlingen. The Central Laboratory provides the majority of the laboratory services. These services include microbiological testing, environmental testing, newborn screening and clinical chemistry testing, and emergency preparedness activities and testing. The South Texas Laboratory provides clinical services for the Rio Grande State Center and the outpatient clinic at the South Texas Health Care System. This laboratory also serves as the local public health laboratory for the South Texas area providing testing for TB, potable water, and STD screening. In addition, this laboratory provides testing for bio-threat agents for the South Texas area.

The program has organizational charts and descriptions of units for review located at: http://www.dshs.state.tx.us/orgchart/pps.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $2,922,578 |
| General Revenue | $9,730,099 |
| General Revenue-Dedicated | $12,808,118 |
| Other | $18,716,935 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

The DSHS public health laboratory provides testing services to diagnose and investigate community health problems and health hazards. Services provided by the DSHS laboratory range from prevention-oriented services to urgent analysis of samples collected during investigations of suspected disease outbreaks. Private clinical laboratories focus on testing for the individual patient. While some services may be similar, the public health laboratory focuses on testing that affects the population of the state.

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

The DSHS Laboratory focuses on community health problems and health hazards; private laboratories focus on testing for individual patients.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Dallas County Department Health and Human Services, Corpus Christi-Nueces County Public Health District, El Paso City-County Health and Environmental District, Houston Department of Health and Human Services, Lubbock City Health Department, San Antonio Metro Health District, Tyler-Public Health Laboratory of East Texas, Tarrant County Public Health District, and Wichita Falls-Wichita County Public Health District | These entities are part of the CDC Laboratory Response Network (LRN) and operate a local public health laboratory. | These entities are grantees and coordinate with DSHS on public health and laboratory activities. The LRN laboratory receives federal grant funding through DSHS and provides testing for biological threat agent incidents and other public health emergencies for the counties in their service region. The public health laboratory provides testing for diseases and environmental issues designated by the local jurisdiction. |
| Abilene-Taylor County Public Health District, Austin Department of Health and Human Services, Brazos County Health Department, Greenville-Hunt County Health Department, La Marque-Galveston County Health District, City of Laredo Health Department, Midland Health Department, Paris-Lamar County Health Department, Sweetwater-Nolan County Health Department, Tyler-Northeast Texas Public Health District, and Victoria County Health Department | These entities operate local public health laboratories. | These entities coordinate with DSHS on public health and laboratory activities. The public health laboratory provides testing for diseases and environmental issues designated by the local jurisdiction. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| EPA | EPA mandates drinking water testing and provides guidance for testing. EPA, Region 6, is a resource for environmental testing questions and issues and coordinates for environmental emergency preparedness. | EPA is grantor and regulator to DSHS. EPA, Region 6, serves as a consultant to DSHS |
| CDC | CDC serves as a reference for infectious disease testing; provides testing methodologies, reagents, and materials; and coordinates the LRN. CDC also provides reference materials and proficiency testing services for newborn screening. | CDC is a grantor and consultant to DSHS. |
| U.S. Federal Drug Administration (FDA) | FDA mandates food, milk, and shellfish testing and provides guidance and assistance. | FDA regulates certain DSHS activities. |
| Department of Homeland Security | The Department of Homeland Security directs the Biowatch Testing Program. | The Department of Homeland Security provides staff, equipment, and supplies to the Central Laboratory for Biowatch testing. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

The program does not have any contracts except for supplies and equipment necessary for the laboratory services performed.

**L. Provide information on any grants awarded by the program.**

The program does not award grants.

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

**Regional and Local Health Services (RLHS) Division**
David Gruber, Assistant Commissioner

**FTEs: 963.4**

The RLHS Division coordinates, standardizes, and provides regional public health services and assists local health departments across the state. The division provides central oversight to the operation of the eight health service regions (HSRs) and supports the DSHS regional medical directors, who lead the service delivery operations in the HSRs. Additionally, the division provides strategic leadership and direction to ensure public health preparedness for bioterrorism, natural epidemics, and other public health threats and emergencies in Texas. Detailed information about regional and local health services administration and public health preparedness and response is included in separate Section VII descriptions.

Note: Many staff organizationally assigned to RLHS and included in the above FTE count are officed in the regions and provide services through one of the programs described in other Section VII descriptions. Those FTEs are funded by those program strategies and are reported in the corresponding Section VII descriptions.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Regional and Local Health Services (RLHS) Administration |
| **Location/Division** | 1100 W. 49th Street, Austin - RLHS Division |
| **Contact Name** | David Gruber, Assistant Commissioner, RLHS Division |
| **Actual Expenditures, FY 2012** | $1,525,544 |
| **Number of Actual FTEs as of June 1, 2013** | 22.6 |
| **Statutory Citation for Program** | Chapter 121, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

RLHS Administration provides central oversight to the operation of the eight DSHS health service regions (HSRs) and supports DSHS regional medical directors, who lead the service delivery operation. Staff facilitates coordination of cross cutting programmatic and operational issues and provides agency liaison activities with local health departments (LHDs), local health authorities, and various public health associations in order to maintain and enhance continuous collaborative relationships throughout Texas. Major activities include the following.

**HSRs**

HSRs provide leadership and coordination for public health issues within the regions, including disaster preparedness and response. HSRs provide essential public health services directly to residents in areas not served by a LHD and carry out statutorily defined local health authority (LHA) duties for areas without a LHA, as well as provide support as needed to LHDs and districts.

**Regional Liaison Services**

This staff serves as the primary contact for the HSRs, as well as DSHS central office programs. Staff collaborates with state and local public health officials on public health policy development and public health advocacy, conducts assessment and evaluation of public health systems and effectiveness, and provides public health consultation and technical assistance to other health and human services agencies regarding shared issues.

**Local Liaison Services**

This staff serves as the primary contact for LHDs and facilitates discussion of program policies and issues impacting local public health services. They provide consultation and technical

assistance to promote quality, efficiency, and effectiveness in the delivery of essential local public health services. Additionally, staff conducts assessment and evaluation of public health systems and effectiveness, facilitates the involvement of LHDs in DSHS initiatives, in coordination with public health associations, and manages activities related to LHAs. They also coordinate funding for public health improvement activities to support the local public health system infrastructure for the State of Texas.

**Contract Management Oversight Services**

This staff acts as the liaison between contractors and DSHS program and contract staff and serves as the single point of contact for contractual accountability activities between the division and contractors. Staff reviews contractor expenditure data, performance reports, and other pertinent data as it relates to contractor performance, according to contract terms. Staff processes contract renewals, initiates contract amendments, and coordinates approval of amendments with appropriate division managers. Additionally, they monitor activities to ensure local services adhere to requirements and meet projected goals and objectives, and monitor the division's operating budget and the LHD contract funds to ensure the budget is not overspent.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

RLHS Administration evaluates effectiveness and efficiency through ongoing analyses of projects and response activities.

**West Nile Virus Response**

DSHS supported the response to a serious West Nile Virus (WNV) outbreak beginning in August 2012. Although cases were statewide, the most severe cluster of illness occurred in the Dallas/Ft. Worth region. During the outbreak, DSHS maintained statewide situational awareness; activated the State Medical Operations Center to manage requests for support from regional and local health agencies; coordinated and monitored aerial and ground spraying activities in the Dallas/Ft. Worth region; developed and promoted public service announcements; managed a high volume of media requests; and compiled and reviewed lab reports, epidemiological trends, and information on mosquito trapping and pools.

**Accreditation of Local Public Health Entities**

RLHS concluded its fiscal year 2012 contract with the University of North Texas Health Science Center (UNTHSC) to improve state and local readiness for public health accreditation as described in the National Public Health Improvement Initiative (NPHII) application. UNTHSC conducted focus groups and completed a readiness assessment, a report of LHDs accreditation readiness, and a toolkit and trainings. RLHS is contracting with UNTHSC in fiscal year 2013 with additional funds from NPHII to identify two or three LHDs that will receive remote and on-site

guidance and assistance on preparing for two or more components of accreditation, as identified by the Public Health Accreditation Board.

**LHA Education and Coordination**

LHAs are physicians appointed at the municipal/county level with broad responsibility to administer state and local laws relating to public health within the appointing body's jurisdiction. It is essential that LHAs receive education, guidance, and coordination in order for them to be effective in fulfilling their statutory duties. RLHS, in partnership with the Galveston County Health District, hosted a meeting of Texas LHAs in order to improve communication and share best practices. As an outcome of this meeting, DSHS established a steering committee to do the following.

- Develop programs that will assure a basic understanding of the roles and responsibilities of LHAs.
- Explore training opportunities in collaboration with schools of public health and other academic centers.
- Enhance existing methods of disseminating critical public health information to LHAs in a timely and effective manner.

**Public Health Funding and Policy Committee**

RLHS provides oversight and staffing to the Public Health Funding and Policy Committee, created by S.B. 969, 82nd Legislature, Regular Session, 2011. The Committee consists of nine public health professionals representing local and regional health departments, local health authorities, and schools of public health, all appointed by the DSHS Commissioner. The legislation requires the Committee to do the following.

- Define core public health services a local health department should provide.
- Evaluate public health in Texas and identify initiatives for areas that need improvement.
- Identify all funding sources available for use by local health entities to perform core public health functions.
- Establish public health policy priorities.
- Make formal recommendations, at least annually, to DSHS regarding the use and allocation of funds available exclusively to local health entities to perform core public health functions; ways to improve the overall health of Texans; and methods for transitioning from a contractual relationship between DSHS and the local health entities to that of a cooperative-agreement.

The Committee conducted a survey to collect services provided by and funding sources of LHDs in the state and completed its annual report to the Governor and Legislative Budget Board.

**HSRs**

HSRs provide essential public health services that promote and protect the health of Texans, including activities to prevent disease, protect against environmental hazards, prevent injuries, promote healthy behavior, respond to disasters, and ensure access to health services.

Examples of the many activities performed in the HSRs in the last six months include:

- conducting large-scale tuberculosis investigations in HSRs 1, 2/3, and 6/5;
- responding to the WNV outbreak in HSR 2/3;
- working with counties to ensure continuity of services and funding as they realign some of their public health programs under the 1115 Healthcare Transformation Waiver process;
- working with area coalitions and local partners on Preventable Hospitalizations Grants and Texas Transformation Grants; and
- conducting Operation Lone Star during the last week of July. Approximately 8,000 individuals were seen in five counties in South Texas. This is a joint training exercise with DSHS, local public health entities, other Health and Human Services System agencies, Texas Military Forces, and U.S. Public Health Services to bring medical care and immunizations to uninsured indigent populations along the border.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**2006** – DSHS creates the RLHS Division to serve the needs of local public health agencies, DSHS HSRs, and local communities in building and maintaining capacity to provide essential public health services responsive to local needs.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

The RLHS Division serves the needs of local public health agencies, DSHS HSRs, and local communities in building and maintaining capacity to provide essential public health services responsive to local needs in Texas. RLHS represents and supports ongoing, diverse public health functions and operations that cross division lines, while strategically working across the agency for the design and delivery of coordinated public health services at the local, regional, and state level. The division reflects DSHS' commitment to work in partnership with agencies, providers, and communities in order to build and maintain the capacity to provide essential public health services responsive to local needs.

The RLHS Division coordinates contracts, public health nursing, and public health improvement activities with regional offices. The division also facilitates information sharing with LHDs and LHAs. The division performs legislative monitoring and internal and external liaison services on cross cutting public health issues; manages the community preparedness budget, contract, and grant administration; promotes health and prevents disease and injury; and effectively responds to all types of health emergencies including bioterrorism, infectious disease outbreaks, and natural disasters.

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The Assistant Commissioner for the RLHS Division reports directly to the Commissioner and oversees the activities of the RLHS Division. The Community Preparedness Section resides within the division, as do the agency's eight HSR offices.

A regional medical director who reports directly to the RLHS Assistant Commissioner heads each HSR. Each regional office handles the following responsibilities.

- Provides essential public health services that promote and protect the health of all Texans, including activities to prevent diseases, protect against environmental hazards, prevent injuries, promote healthy behavior, respond to disasters, and ensure access to health services.
- Serves as the LHD where local jurisdictions are unable to fulfill that role.
- Provides support, when requested, to LHDs or local health districts.
- Carries out statutorily defined LHA duties for areas without a locally appointed health authority.
- Conducts regional disaster planning and preparedness activities related to mitigating natural or manmade chemical, biological, radiological, nuclear, or explosive events.

Details about health services regions are located at:
http://www.dshs.state.tx.us/regions/default.shtm.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $159,546 |
| General Revenue | $1,330,978 |
| General Revenue-Dedicated | $35,020 |
| Other | $0 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| LHDs | LHDs provide public health services such as restaurant inspections, immunizations, tuberculosis treatment, and human immunodeficiency virus (HIV) and sexually transmitted disease (STD) treatment. In some cases, HSRs supplement the services offered by LHDs and, in other cases, LHDs provide all services. | According to Chapter 121, Texas Health and Safety Code, the State is the guarantor of public health services and must fill in where LHDs do not offer those services. The LHDs can choose which services they offer, because no legislative mandate describes minimal service provision requirements for LHDs. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

The RLHS Division coordinates the delivery of public health services between local and regional public health services, LHDs, and DSHS programs. HSRs provide services where no LHD currently exists or where the LHD has requested assistance. The RLHS Division also communicates closely with the various public health associations and organizations by attending their meetings regularly, providing policy updates, and hearing concerns and recommendations from the membership.

**J. If the program or function works with local, regional, or federal units of government, include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Local units of government that contract with DSHS | City and county governments that are involved in the provision of healthcare services to their respective constituents. | DSHS conducts fiscal monitoring of local units of government when determined appropriate based on risk and provides financial training and technical assistance as needed. |
| Local and county governments, LHDs, and health authorities | These local entities are involved in public health nuisance matters. | DSHS is a necessary and indispensable party to litigation by local governments in public health nuisance actions under Chapter |

| Name | Description | Relationship to DSHS |
|---|---|---|
| | | 343, Texas Health and Safety Code. |

**Regional Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Councils of Government (COGs) | COGs are voluntary associations of local governments formed under Texas law that deal with the problems and planning needs that cross the boundaries of local governments or that require regional attention. COGs coordinate planning and provide a regional approach to problem solving through cooperative action. | HSRs are key participants in Homeland Security Task Forces coordinated by the COGs. In addition, a number of HSRs contract with COGs to obtain assistance and assure coordination in emergency preparedness planning, training, and exercising. DSHS Business Continuity works with COGs in the coordination of planning and response activities as needed. |
| Disaster District Committee (DDC) | The DDC is the first step in management of state resources during emergencies. When an emergency occurs or threatens to occur and is beyond the capability of local government to respond, the local government chief elected official may request state assistance through the appropriate DDC Chairman prescribed in the state emergency management plan. | HSR employees are the designated representatives from DSHS on all DDCs in Texas. These staff members take the lead in coordinating Emergency Support Function 8 (Health and Medical) activities during emergency events. |
| Regional Advisory Councils (RACs) | The RACs facilitate the development, implementation, and operation of a comprehensive emergency services plan encompassing all healthcare-related issues, including trauma, natural and manmade disasters, and medical and population specific needs. | DSHS defines the accepted standards of care in an emergency response in order to decrease illness and death. HSRs coordinate emergency response and recovery activities with the RACs in their areas of coverage. HSR staff takes the lead for the public health function whenever an appropriate RAC activates a Regional Medical Operation Center. In addition, HSRs partner |

| Name | Description | Relationship to DSHS |
|---|---|---|
| | | with RACs and infection control officers in their constituent hospitals in gathering and analyzing communicable disease information. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Native American tribes living in Texas | Three federally recognized Native American tribes reside in Texas: Alabama-Coushatta, Kickapoo, and Ysleta del Sur Pueblo. | The DSHS HSRs provide technical assistance to tribal nations in the development of emergency response and recovery plans and in planning for outbreak control. |
| Federal prisons | Federal prisons located in Texas house offenders charged with federal crimes. | Upon request, HSRs assist federal prisons in helping to assure effective communicable disease control and prevention, including education, screening, technical assistance, disease surveillance, and treatment. |
| Federal detention centers | Federal detention centers located in Texas house offenders who have allegedly committed a federal crime but who have not yet been brought to trial. | Upon request, HSRs assist federal detention centers in helping to assure effective communicable disease control and prevention, including education, screening, technical assistance, disease surveillance, and treatment. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

RLHS establishes contracts with a focus on providing public health functions at the local level. Governmental entities, such as LHDs, carry out the services. In addition, client services contracts within the DSHS HSRs include services for the following:

- tuberculosis (TB) directly observed therapy;

- TB elimination;
- radiological interpretation;
- medical laboratory services;
- radiographic imaging;
- medical evaluation;
- alteration of TB drugs;
- professional services (doctors, nurses, and other healthcare professionals);
- Women, Infants and Children (WIC) breastfeeding peer counselors; and
- HIV/STD testing, diagnosis, and/or treatment services.

Amount of contracted expenditures in fiscal year 2012: $8,555,211 (DSHS expends funds from various budget strategies across the agency, depending upon the type of services provided)
Number of program contracts: 496 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $414,296 | Northeast Texas Public Health District | Provide essential public health services |
| $317,427 | Tarrant County | Provide essential public health services |
| $314,855 | Galveston County Health District | Provide essential public health services |
| $248,631 | City of Houston | Provide essential public health services |
| $230,095 | City of Laredo | Provide essential public health services |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

DSHS awards grants in the program for the following services:
- local public health services,
- TB directly observed therapy,

- TB elimination,
- radiological interpretation,
- medical laboratory services,
- radiographic imaging,
- medical evaluation,
- alteration of TB drugs,
- professional services (doctors, nurses, and other healthcare professionals),
- WIC breastfeeding peer counselors, and
- HIV/STD testing, diagnosis, and/or treatment services.

Using sub-recipient contracts, the program awards grants in the following manner:
- through open enrollment;
- without competitive solicitation (not required when amount is under $5,000);
- on a sole source basis when an approved sole source justification waives competition; and
- to a state or local governmental entity through direct negotiation and grant contract execution (these entities are exempt from competition).

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

DSHS suggests the following statutory change to assist the program in performing its functions.

**Chapter 121, Texas Health and Safety Code** – This statute promulgates responsibilities of local LHAs. These physicians are state officers performing duties necessary to implement and enforce laws protecting public health. In counties that have no LHAs, DSHS regional directors serve in this capacity. Specific issues that require attention follow.
- Roles and responsibilities between LHAs, LHDs, and DSHS are unclear.
- Many counties are unable to compensate LHAs adequately.
- Regional directors currently serve as the LHA for multiple rural counties. If a widespread epidemic or disaster should occur, the workload would be too difficult for these regional directors to respond effectively.
- LHAs should receive enhanced educational opportunities.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

## VII. GUIDE TO AGENCY PROGRAMS - CONTINUED

**A. Provide the following information at the beginning of each program description.**

| | |
|---|---|
| **Name of Program or Function** | Community Preparedness |
| **Location/Division** | 1100 W. 49th Street, Austin - Regional and Local Health Services (RLHS) Division |
| **Contact Name** | David Gruber, Assistant Commissioner, RLHS Division |
| **Actual Expenditures, FY 2012** | $86,852,813 |
| **Number of Actual FTEs as of June 1, 2013** | 253.9 |
| **Statutory Citation for Program** | Chapter 121, Texas Health and Safety Code |

**B. What is the objective of this program or function? Describe the major activities performed under this program.**

Community Preparedness has the following primary objectives.

- Develop and coordinate a statewide public health preparedness and response program to address the public health and medical response to all hazards, including natural disasters, major accidents, and terrorist acts.
- Work in partnership with United States and Mexico health entities to coordinate efforts to address bi-national public health issues.

Major activities include the following.

**Preparedness Coordination**

Staff in the Community Preparedness Section (CPS) coordinates and directs planning, training, and exercises for the public health and medical response to all public health emergencies and catastrophic events.

**Response and Recovery**

CPS staff initiates and manages the public health and medical response to disasters, provides response and recovery assistance to local governments, and coordinates the delivery of federal response assets.

**Integration of Public Health and Medical Preparedness Efforts, Strategies, and Resources**

CPS staff collaborates and strategizes preparedness activities with regional, local, tribal, and international health and medical organizations; public and private hospitals; healthcare systems; and non-governmental organizations. Additionally, staff identifies assets and understands the capacity and capability of stakeholders and response partners. Staff identifies

strategies and develops plans for assessing statewide preparedness, and provides subject matter expertise on emerging threats and preparedness activities.

**Grant and Budget Development and Tracking and Contract Monitoring**
CPS staff coordinates grants, budgets, and required reports for the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness cooperative agreement. This agreement provides funding to enable DSHS central office, health service region (HSR) offices, and local health departments (LHDs) to have the capacity and capability to prepare effectively for the public health consequences of infectious disease outbreaks, natural disasters, and terrorist threats, including chemical, biological, radiological, and nuclear attacks. In addition, CPS coordinates the Hospital Preparedness Program. Through this program, the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response provides resources to help hospitals and healthcare systems prepare for and respond to public health emergencies.

**C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.**

The measurement of preparedness activities is a continuous, dynamic process that includes initial planning, staff training, and exercises. Evaluation occurs at each of these three steps. Staff then repeats this process using a variety of disaster scenarios to identify and address gaps and conducts comprehensive after-action reviews of actual responses. DSHS uses lessons learned to modify plans and address identified gaps.

An example of this process is the comprehensive, after-action assessment of the novel H1N1 influenza health and medical response in 2009. The process began with a series of interviews to obtain information from DSHS subject matter experts, DSHS leadership, and leadership of other organizations. Interviews with subject matter experts provided background information on areas of programmatic response (for example, vaccine allocation and distribution) and updates on response activities. Interviews with DSHS and other leadership organizations identified high-level, strategic input on the response. A comprehensive data gathering phase followed that included input from a broad range of internal and external stakeholders. DSHS stratified stakeholder groups as professional or state-level partners, regional partners, DSHS Austin staff, and DSHS HSR staff. Staff conducted data gathering sessions statewide using structured interviews, focus groups, and surveys. From this process, DSHS developed an improvement plan that compiled recommendations and corrective actions along with completion timelines to assure implementation.

DSHS preparedness and response activities rely heavily upon collaborative partnerships with multiple disciplines across a variety of agencies and jurisdictions. These critical partnerships across Texas include 45 LHDs, 566 hospitals, and 16 state agencies.

**D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.**

**2006** – CPS undergoes a reorganization to integrate public health and medical preparedness better. The section creates four distinct branches along with a Strategic Preparedness Team. Those branches evolve in future years and now include the Preparedness Coordination Branch, Health Care Systems Branch, Public Health Emergency Preparedness Branch, and the Response and Recovery Unit.

**2008** – House Bill 1831 establishes a disaster and emergency education program designed to educate the citizens of Texas on disaster and emergency preparedness, response, and recovery.

**2012** – DSHS transfers CPS to the RLHS Division. Due to this change, DSHS renames the Prevention and Preparedness Services Division, the former location of CPS, the Disease Control and Prevention Services Division. CPS works closely with other RLHS Division staff to assist with mitigation, preparedness, response and recovery from natural disasters, terrorist attacks, and other public health emergencies.

**E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.**

Disasters are possible anywhere in Texas; therefore, DSHS preparedness and response activities serve the entire population of Texas. Texas stands out as the state with more federally declared disasters than any other state, with 86 declarations between 1953 and 2012. Between 2005 and 2012, these declarations have included floods, hurricanes, tropical storms, tornadoes, droughts, and wildfires.

**Federal Emergency Management Agency**
**Ranking of States by Number of Federally Declared Disasters, 1953–2012**

| Rank | State | Disasters Declared |
|---|---|---|
| 1 | Texas | 86 |
| 2 | California | 78 |
| 3 | Oklahoma | 72 |
| 4 | New York | 66 |
| 5 | Florida | 65 |

| Year | Disaster Type / Name |
|---|---|
| 2005 | Hurricane Rita |
| 2006 | Extreme Wildfire Threat |
| 2006 | Flooding |
| 2007 | Severe Storms and Tornadoes |
| 2007 | Severe Storms, Tornadoes, and Flooding |
| 2007 | Tropical Storm Erin |
| 2008 | Hurricane Dolly |
| 2008 | Hurricane Ike |
| 2010 | Hurricane Alex |
| 2011 | Wildfires (April 6 – August 29) |
| 2011 | Wildfires (August 30 – December 31), including Bastrop County fire |

**F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. Indicate how field/regional services are used, if applicable.**

The RLHS Division, CPS administers all public health preparedness and response activities. The section provides strategic leadership and direction to ensure public health preparedness. RLHS organizes the section into four branches (Health Care Systems Preparedness, Public Health Emergency Preparedness, Preparedness Coordination, and Strategic Preparedness) and one unit (Response and Recovery). The section determines preparedness activities based on the public health threats of Texas, and the goals and requirements outlined in federal preparedness guidance documents. Preparedness and response activities occur within and across the local, regional, and state levels. Stakeholders at these levels are extensively involved in determining preparedness priorities for the state and funding allocations for LHDs, healthcare systems, HSRs, and preparedness projects administered by DSHS.

DSHS coordinates a grant and budget development process that includes stakeholder involvement at all levels. This process ultimately results in the disbursement of the majority of funding received from federal grantors to local and regional preparedness providers who are obligated through the DSHS contracting process to perform preparedness activities consistent with priorities that address the State's preparedness goals. Providers receive technical assistance from DSHS program staff on the implementation of preparedness activities. DSHS staff conducts quality assurance visits to ensure compliance with federal guidance and with program guidance on specific preparedness activities developed by DSHS subject matter experts.

Pursuant to National Incident Management System, DSHS provides operational policies and procedures, guidelines, and instructions for the integrated management of health and medical services in preparation for, and in the aftermath of, a major emergency or catastrophic incident. DSHS provides for coordinated health and medical services to augment local

resources, as well as assistance in damage assessment and the restoration of essential health and medical services within the disaster area, as described below.

- DSHS provides state support and assistance, when requested, as quickly and as efficiently as possible. Consistent with the priority of need, attempts to provide assistance focus on providing supplemental assistance to local governments in identifying and meeting the health and medical needs of victims of a major emergency or catastrophic disaster.
- DSHS obtains additional support through state and/or federal medical response teams, such as the Disaster Medical Assistance Teams, the Disaster Mortuary Operational Response Teams, and the Veterinary Medical Assistance Teams.
- DSHS and the designated support agencies receive requests for assistance from local or regional jurisdictions with public health emergencies. DSHS representatives determine the most effective means of delivering the requested support, identify requested resources, and deliver them wherever needed.
- Upon notification of a significant event requiring state response, DSHS staff alerts pre-identified personnel to be prepared to meet requirements for representing the Health and Medical Services Emergency Support Function (ESF) 8 at various operations and command centers.

DSHS notifies all support agencies and organizations and requests that they provide representation, as necessary. Each support agency and organization is responsible for ensuring sufficient program staff members are available to accomplish the emergency response mission. Individuals representing agencies and organizations providing health and medical services support have extensive knowledge of their respective resources and capabilities. These representatives have direct or rapid access to the appropriate authority for committing those resources during activation.

**G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).**

| Funding Source | Amount |
|---|---|
| Federal | $70,681,188 |
| General Revenue | $9,990,902 |
| General Revenue-Dedicated | $4,867,329 |
| Other | $1,313,394 |

**H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions to the target population. Describe the similarities and differences.**

**Internal Programs**

| Name | Similarities | Differences |
|---|---|---|
| Regulatory Services Division (RSD) | This division is also involved in planning and response to emergencies. | Primary focus of RSD is regulated industries and professions. |
| HSRs | HSRs are also involved in planning and response to emergencies. | Focus of the HSR is the geography of regional boundary. HSRs serve as the local public health authority in areas without a public health department. |

**External Programs**

| Name | Similarities | Differences |
|---|---|---|
| LHDs | LHDs are involved in planning and response to emergencies. | DSHS applies state assets to supplement local efforts, provides resources when local assets are exhausted, and coordinates the delivery of federal assets. |
| Health and Human Services Commission (HHSC) | HHSC is involved in planning and response to emergencies. | HHSC provides trained employees, pre-designated back-up facilities, resources, and associated systems to assist in emergencies. |
| Texas Department of Aging and Disability Services (DADS) | DADS is involved in planning and response to emergencies. | DADS assists in identifying licensed facilities in disaster areas that house persons with special needs and monitors licensed long-term care facilities for implementation of disaster plans formulated by the facilities and agencies under contract. During emergency and disaster situations, DADS monitors the evacuation of facilities and facilitates communication with their destination locations. DADS coordinates with local, state, private, and federal resources and agencies in meeting the needs of special needs persons that reside outside facilities licensed by DADS. |
| Department of Assistive and Rehabilitative Services (DARS) | DARS is involved in planning and response to emergencies. | DARS assists with resource information and identifies accommodation requirements for persons with disabilities and special needs. DARS provides liaison |

| Name | Similarities | Differences |
|---|---|---|
| | | between major coalitions, advocacy organizations for persons with disabilities, and the health and medical community during disasters. |
| Department of Family and Protective Services (DFPS) | DFPS is involved in planning and response to emergencies. | DFPS assists vulnerable populations including children who are abused, neglected, or lost and elderly adults. |
| Texas Division of Emergency Management (TDEM) | TDEM is involved in planning and response to emergencies. | TDEM oversees all aspects of a disaster response, beyond the health and medical focus of DSHS. |
| Texas Military Forces | Military forces participate in planning and response to emergencies. | The response of Texas Military Forces expands beyond health and medical to include all state response. |
| Salvation Army | The Salvation Army is involved in planning and response to emergencies. | The Salvation Army provides mass feeding operations for special needs shelters, pastoral crisis counseling, and emergency personnel needs. |
| American Red Cross | The American Red Cross is involved in planning and response to emergencies. | The American Red Cross provides general shelters and services, and assists in coordinating health and medical volunteers. |
| Texas Department of Criminal Justice (TDCJ) | TDCJ is involved in planning and response to emergencies. | TDCJ provides first aid services, provides medical personnel, and assists with medically related transportation of ill, injured, or individuals with special needs. |
| Texas Commission on Environmental Quality (TCEQ) | TCEQ is involved in planning and response to emergencies. | TCEQ provides assistance in evaluating the quality of potable water and provides technical assistance for locating and/or establishing an authorized waste disposal facility. TCEQ provides technical assistance in the disposition of dead livestock and/or poultry, as a result of a major emergency or disaster. |
| Texas Animal Health Commission (TAHC) | TAHC is involved in planning and response to emergencies. | TAHC prevents, surveys, controls, diagnoses, and eradicates certain diseases and conditions affecting livestock, poultry, and exotic animals, |

| Name | Similarities | Differences |
|---|---|---|
| | | some of which may have human health implications. TAHC provides advice and assists in the disposition of dead, injured, or displaced livestock and poultry, as a result of a major emergency or disaster; provides advice for the care of injured livestock and other animals, as a result of a major emergency or disaster; and assists the state and local jurisdictions in coordinating the evacuation and sheltering of companion animals (for example, pets, service animals, etc.), and livestock, as a result of a hurricane or similar event. |

**I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.**

The State Emergency Management Plan outlines specific ways each agency will eliminate duplication of public health and medical preparedness and response activities at the local, regional, and state levels. By integrating preparedness planning activities at all levels, DSHS further reduces duplication of efforts and services and fosters improved collaboration among public health and medical preparedness providers. DSHS takes the following steps to reduce duplication of activities.

- Partner with health and medical preparedness managers at the local, regional, state, and national levels.
- Accomplish integrated planning at the state level with health and medical professionals, emergency management officials, and other public health and medical response organizations.
- Communicate effectively by involving partners in early planning stages, maintaining communication throughout the preparedness process.
- Keep partners informed as new guidance and information is received on funding.
- Collaborate with partners to optimize use of current federal preparedness funds and prepare for anticipated reductions.
- Provide guidance and technical assistance in a timely manner.

Additionally, health and medical partners at the regional and local levels work together to accomplish the following activities.

- Assess public health threats.
- Prioritize preparedness needs.
- Integrate planning, training, and exercise activities.
- Facilitate the accomplishment of common goals by sharing information and resources and developing joint strategies for emergency preparedness stakeholders.
- Include mental health/behavioral health partners.
- Collaborate with emergency management.
- Support preparedness efforts in surrounding communities and in the regions.
- Ensure interoperability of communication equipment and coordination of communication processes.
- Reduce duplication.
- Maximize the use of federal preparedness funds and address anticipated reductions.
- Work with DSHS to develop and meet integrated preparedness planning performance measures.

The current Texas Homeland Security Strategic Plan 2010-2015 capitalizes on the successes of the previous plan (Texas Homeland Security Strategic Plan 2005-2010) that improved interoperability and coordination among agencies and jurisdictions throughout Texas. The existing plan takes these efforts a step further by outlining the direction and prioritization of effort for all stakeholders and guiding decision making about securing and applying resources during an emergency.

**J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.**

**Local Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| County/local governments | These administrative authorities in local cities and counties are involved with disaster response and preparedness activities in their jurisdictions. | DSHS coordinates planning, exercising, and training with local governments. During disasters that overwhelm local resources, local governments also request health and medical assistance from DSHS. |
| LHDs | LHDs provide public health services and participate in disaster response and preparedness activities in their jurisdictions. | LHDs are the recipients of preparedness grants and contracts. |

**Regional Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| Councils of Government (COGs) | COGs are voluntary associations of local governments formed under Texas law that, as one of their responsibilities, assist with a regional coordinated response during a disaster. | DSHS sometimes coordinates planning, exercising, and training with local governments through a regional council. COGs may also request assistance when local resources are exhausted. |
| Trauma Service Areas | The Texas Board of Health adopted rules in 1992 to divide the state into 22 called trauma service areas. Each area develops and implements a regional trauma system plan and a delineated trauma facility designation process. | These are DSHS contractors that include health and medical partners who are the recipients of healthcare systems preparedness contracts and grants. |

**Federal Units of Government**

| Name | Description | Relationship to DSHS |
|---|---|---|
| CDC | CDC provides information to enhance health decisions and promotes health through partnerships with state health departments and other organizations. | CDC is a federal funder and public health partner. CDC provides resources to help public health departments prepare for and respond to public health emergencies through the Public Health Emergency Preparedness Program. |
| Office of the Assistant Secretary for Preparedness and Response (OASPR) | OASPR within the U.S. Department of Health and Human Services has the responsibility to lead the nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters. | OASPR is a federal funder and public health partner. OASPR provides resources to help hospitals and healthcare systems prepare for and respond to public health emergencies through the Hospital Preparedness Program. |
| Federal Emergency Management Agency (FEMA) | FEMA coordinates the response when disasters overwhelm the resources of local and state authorities. | FEMA is an emergency preparedness and response partner. |
| U.S. Department of Defense (DOD) | DOD coordinates and supervises all agencies and functions of the government relating directly to national security and the U.S. armed forces. | DOD is an emergency preparedness and response partner. |

| Name | Description | Relationship to DSHS |
|---|---|---|
| U.S. Food and Drug Administration (FDA) | The FDA is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, the nation's food supply, cosmetics, and products that emit radiation. | FDA provides technical assistance and is an emergency preparedness and response partner. |
| U.S. Department of Agriculture (USDA) | The USDA is responsible for developing and executing federal government policy on farming, agriculture, and food. | USDA provides technical assistance and is an emergency preparedness and response partner. |
| Federal Bureau of Investigation (FBI) | FBI serves as both a federal criminal investigative body and an internal intelligence agency. | FBI provides technical assistance and is an emergency preparedness and response partner. |
| U.S. Environmental Protection Agency (EPA) | EPA protects human health and the environment. | EPA provides technical assistance and is an emergency preparedness and response partner. |

**K. If contracted expenditures are made through this program please provide:**

- **a short summary of the general purpose of those contracts overall;**
- **the amount of those expenditures in fiscal year 2012;**
- **the number of contracts accounting for those expenditures;**
- **top five contracts by dollar amount, including contractor and purpose;**
- **the methods used to ensure accountability for funding and performance; and**
- **a short description of any current contracting problems.**

Contracts established in this program focus on the mitigation, preparedness, response and recovery from natural disasters, terrorist attacks, and other public health emergencies. Examples of activities include:

- hospital preparedness program to enhance the ability of hospitals and healthcare systems to prepare for and respond to bioterrorism and other public health emergencies with a primary focus on coalition building;
- public health emergency preparedness (e.g. Cities Readiness Initiative, upgrade and integrate lab response networks, and assess risks and propose strategies for reducing public health hazards);
- medical staffing during an emergency or disaster response; and
- response and recovery efforts (e.g. mortuary services and confidential contracts for points of dispensing emergency immunizations during public health emergencies).

Amount of contracted expenditures in fiscal year 2012: $41,917,438
Number of program contracts: 734 (includes contracts with no expenditures)

The top five contracts for the program are as follows.

| Amount Expended FY 12 | Contractor | Purpose |
|---|---|---|
| $4,603,571 | North Central Texas Trauma Regional Advisory Council | Prepare regional healthcare system for terrorism or other health emergencies |
| $2,752,381 | Southeast Texas Trauma Regional Advisory Council | Prepare regional healthcare system for terrorism or other health emergencies |
| $2,365,774 | Southwest Texas Trauma Regional Advisory Council | Prepare regional healthcare system for terrorism or other health emergencies |
| $1,425,721 | Dallas County | Prepare regional healthcare system for terrorism or other health emergencies |
| $1,356,092 | City of Houston | Prepare regional healthcare system for terrorism or other health emergencies |

To ensure accountability, the assigned contract manager monitors contract performance and takes action to resolve performance and compliance issues as needed. Additionally, staff in the Chief Financial Office audits each invoice to confirm accuracy. The accounting system includes edits to match invoices with purchase orders and verification of receipt of goods and services. Staff in the Chief Operating Office performs target financial compliance reviews and provides consultative services and technical assistance on financial management of contracts. DSHS uses an automated contract management system, SOURCE.Net, to document contractor information, contract management activities, and monitoring reports. The program has no known contracting problems.

**L. Provide information on any grants awarded by the program.**

DSHS awards grants in this program for the following services:

- hospital preparedness program,
- public health emergency preparedness,
- medical staffing during an emergency or disaster response, and
- response and recovery efforts.

Using sub-recipient contracts, the program awards grants in the following manner:

- through open enrollment and memorandums of agreement;
- through competitive solicitations;

- on a sole source basis when an approved sole source justification waives competition; and
- to a state or local governmental entity through direct negotiation and grant contract execution (these entities are exempt from competition).

**M. What statutory changes could be made to assist this program in performing its functions? Explain.**

The program does not have any statutory changes to suggest.

**N. Provide any additional information needed to gain a preliminary understanding of the program or function.**

The preceding discussion is sufficient to gain a preliminary understanding of the program.

**O. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Not applicable.

**P. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.**

Not applicable.

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## VIII. STATUTORY AUTHORITY AND RECENT LEGISLATION

**A. Fill in the following chart, listing citations for all state and federal statutes that grant authority to or otherwise significantly impact your agency. Do not include general state statutes that apply to all agencies, such as the Public Information Act, the Open Meetings Act, or the Administrative Procedure Act. Provide information on Attorney General opinions from FY 2009 – 2013, or earlier significant Attorney General opinions, that affect your agency's operations.**

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Alcoholic Beverage Code, § 106.115 | Provides for the Department of State Health Services (DSHS) approval and oversight regarding court-ordered alcohol educational programs for certain minors. |
| Civil Practice & Remedies Code, § 74.102 | Creates Texas Medical Disclosure Panel to determine which risks and hazards related to medical care and surgical procedures must be disclosed by healthcare providers or physicians to their patients or persons authorized to consent for their patients and to establish the general form and substance of such disclosure. The disclosure panel is administratively attached to DSHS. |
| Code of Criminal Procedure, Article 16.22 | Provides for examination and transfer of defendants suspected of having mental illness. |
| Code of Criminal Procedure, Article 18.05 | Provides DSHS authority to obtain warrants to inspect for health hazards. |
| Code of Criminal Procedure, Article 42.12 § 13(h) | Provides for DSHS approval and oversight regarding court-ordered educational programs for individuals convicted of driving while intoxicated (DWI). |
| Code of Criminal Procedure, Article 42.12 § 13(j) | Provides for DSHS approval and oversight regarding court-ordered educational programs for DWI repeat offenders. |
| Code of Criminal Procedure, Article 46.020 (hyperlink not available) | Relates to incompetency to stand trial. (This article expired on 01/01/2004 but still has application in certain cases.) |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Code of Criminal Procedure, Article 46.03 (hyperlink not available) | Relates to the insanity defense. (This article expired on 01/01/2004 but still has application in certain cases.) |
| Code of Criminal Procedure, Chapter 46B | Relates to incompetency to stand trial and the procedures for committing criminal defendants into State Hospitals for competency restoration services. |
| Code of Criminal Procedure, Chapter 46C | Relates to raising the insanity defense and the procedures for committing defendants into the State Hospitals for mental health services following insanity acquittal. |
| Code of Criminal Procedure, § 62.4023 | Requires the Council on Sex Offender Treatment by rule to establish, develop, or adopt an individual risk assessment tool or a group of individual risk assessment tools that will predict future sexual recidivism and determine the minimum registration period under 42 U.S.C. § 14071 (Jacob Wetterling Crimes against Children and Sexually Violent Offender Registration Program) for each reportable conviction or adjudication under Chapter 62, Code of Criminal Procedure. |
| Education Code, § 29.012 | Requires memorandum of understanding (MOU) between state agencies to include DSHS to establish respective responsibilities for free and appropriate public education of children with disabilities in state operated and regulated residential facilities. |
| Education Code, § 38.001 | Relates to immunizations for school-age children and the authority of DSHS. |
| Education Code, § 51.933 | Relates to immunizations for college students and the authority of DSHS. |
| Education Code, § 51.976 | Authorizes DSHS to establish requirements for a training program on warning signs of sexual abuse and child molestation for employees of campus programs for minors. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Education Code, § 61.854 | Authorizes DSHS to designate medically underserved areas for resident pharmacists. |
| Family Code, § 1.03 | Relates to the application for a marriage form prescribed by DSHS. |
| Family Code, § 1.07 | Relates to marriage application materials prepared by DSHS concerning human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). |
| Family Code, § 1.92 | Requires DSHS to develop a declaration of informal marriage form. |
| Family Code, Chapter 33 | Relates to judicial approval for a minor's abortion and directs DSHS to pay costs of attorney and produce informational material. |
| Family Code, § 54.033 | Requires DSHS to develop protocols for HIV, AIDS, and sexually transmitted diseases (STD) testing of certain children. |
| Family Code, Chapter 55 | Relates to proceedings concerning children with mental illness. |
| Family Code, Chapter 108 | Provides for the administration of certified records of court orders rendered in suits affecting parent-child relationship, adoptions, determinations of paternity, and the records of a child-placing agency that has ceased operations, by the DSHS Bureau of Vital Statistics. |
| Family Code, § 155.101 | Provides that the DSHS Bureau of Vital Statistics identify the court that last had continuing, exclusive jurisdiction of the child in a suit affecting parent-child relationship upon written request of the court, attorney, or a party. |
| Family Code, § 231.006 | Relates to ineligibility to receive state grants or loans or receive payment of state contracts. |
| Family Code, Chapter 261 | Relates to investigations of child abuse or neglect in facilities licensed or operated by DSHS. |
| Family Code, § 264.503 | Requires DSHS to collect data concerning child fatalities. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Government Code, Chapter 403 | Establishes certain permanent funds from tobacco settlement monies with interest to be appropriated to DSHS. |
| Government Code, Chapter 411, Subchapter F | Authorizes DSHS access to criminal history record information for various applicants and holders of DSHS licenses and employment. |
| Government Code, § 418.186 | Establishes a disaster and emergency education program. |
| Government Code, § 501.054 | Requires the Department of Criminal Justice to consult with DSHS concerning an HIV and AIDS education program for inmates and employees. |
| Government Code, Chapter 531 | Relates to the Health and Human Services Commission (HHSC) and its authority in regard to health and human services (HHS) agencies, including DSHS. |
| Government Code, Chapter 664, State Employees Health Fitness and Education Act of 1983 | Allows agencies to establish fitness programs and requires DSHS to approve them. |
| Government Code, Chapter 2105 | Relates to the administration of block grants. |
| Government Code, § 2105.009 | Authorizes DSHS to administer the federal primary care block grant. |
| Government Code, §§ 2165.301-305 | Requires DSHS to conduct any necessary investigation and testing of indoor air quality in state buildings, on request or referral of an entity with charge and control of the state building. |
| Health and Safety Code, Chapter 11 | Relates to the organization of DSHS. |
| Health and Safety Code, Chapter 12 | Relates to powers and duties of DSHS. Includes provisions regarding distribution of certain vaccines and sera. Allows DSHS to enter into a contract for the sale of lab services, and requires regulatory programs to charge licensing fees in an amount to recover costs of administration. |
| Health and Safety Code, § 12.092 | Authorizes the Commissioner to appoint members to the Medical Advisory Board (attached to DSHS) to make medical reviews of applications to the Department of Public Safety for driver's licenses and/or gun permits. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 13 | Relates to DSHS hospitals and respiratory facilities, including Texas Center for Infectious Diseases. |
| Health and Safety Code, Chapter 31, Texas Primary Health Care Services Act | Provides for delivery of primary healthcare services directly by DSHS and through contractors. |
| Health and Safety Code, Chapter 32, Maternal and Infant Health Improvement Act | Authorizes provision of comprehensive maternal and infant health improvement services and ancillary services to eligible women and infants directly by DSHS or through contractors, and the development of a statewide network of voluntary perinatal healthcare systems, including coordination with adjoining states. |
| Health and Safety Code, Chapter 33 | Requires (with religious opt-out) screening tests for newborns to detect certain phenylketonuria, hypothyroidism, sickle-cell trait, other heritable diseases, and other disorders and establishment of a laboratory by DSHS. Also authorizes provision of diagnostic and/or treatment services by DSHS or through contractors to eligible individuals. Requires DSHS to disclose (via a document that providers must give parents) allowable post-testing uses of blood spots, with parents able to consent (opt-in) for a larger set of residual uses, as described in the statute and allows parent, managing conservator, or guardian of a newborn child (or the child upon majority) to opt-out and direct destruction of the blood spot once testing is completed. If the parent does not opt-in, then DSHS may only allow a smaller set of residual uses, after which the samples must be destroyed two years after collection. |
| Health and Safety Code, Chapter 35, Children with Special Health Care Needs Act | Authorizes provision of early identification, diagnosis and evaluation, rehabilitation, and case management services to eligible chronically ill and disabled children through providers. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 36 | Relates to the special senses and communications program at DSHS for screening children. |
| Health and Safety Code, Chapter 37 | Requires screening of children attending public and private schools in grades 6 and 9 for abnormal spinal curvature by health practitioners or by persons certified through a training program approved by DSHS. |
| Health and Safety Code, Chapter 38 | Establishes a program to detect and treat pediculosis in minors. |
| Health and Safety Code, Chapter 39 | Establishes a children's outreach heart program to provide prediagnostic cardiac screening and follow-up evaluation services to eligible individuals, and to train local physicians and public health nurses in screening and diagnostic procedures. |
| Health and Safety Code, Chapter 40 | Establishes the epilepsy program at DSHS. |
| Health and Safety Code, Chapter 41 | Provides for continuing treatment with blood, blood derivatives, or manufactured pharmaceutical products for eligible individuals with hemophilia through approved providers. |
| Health and Safety Code, Chapter 42 | Provides that DSHS may assist in the development and expansion of programs for the care and treatment of persons with chronic kidney disease, including dialysis and other lifesaving medical procedures and techniques. |
| Health and Safety Code, Chapter 43, Texas Oral Health Improvement Act | Authorizes provision of comprehensive oral health services to eligible individuals. |
| Health and Safety Code, Chapter 44, Sexual Assault Prevention and Crisis Services Act | Authorizes DSHS to promote statewide development of locally based and supported nonprofit programs for survivors of sexual assault and to develop and distribute a protocol and kits to collect and preserve evidence of a sexual assault. |
| Health and Safety Code, Chapter 45 | Allows DSHS to distribute child passenger safety seat systems. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 46 | Authorizes DSHS to reimburse costs of tertiary medical and stabilization services. |
| Health and Safety Code, Chapter 47 | Establishes a newborn hearing screening program at DSHS. |
| Health and Safety Code, Chapter 48 | Authorizes DSHS to regulate promotores and community health workers. |
| Health and Safety Code, Chapter 61, Indigent Health Care and Treatment Act | Requires DSHS to establish standards for counties whose indigent residents require healthcare assistance and reporting requirements for governmental hospitals and counties. |
| Health and Safety Code, Chapter 81, Communicable Disease Prevention and Control Act | Gives DSHS powers and duties related to the prevention and makes responsible for the control of communicable disease. Includes provisions regarding emergencies, confidentiality, (including special provisions regarding HIV test results), reporting requirements, issues related to HIV tests, notice requirements, and investigative powers; requires reports of certain diseases; sets out procedures for the imposition of control measures for persons who have or are suspected of having a communicable disease, for court-ordered management of persons who violate those control measures and quarantine, and for court-ordered management of persons with communicable diseases. Establishes certain criminal penalties. |
| Health and Safety Code, Chapter 82, Texas Cancer Incidence Reporting Act | Establishes the cancer registry at DSHS. |
| Health and Safety Code, Chapter 83 | Requires DSHS to collect reports on exposure to Agent Orange. |
| Health and Safety Code, Chapter 84, Occupational Disease Reporting Act | Requires DSHS to collect reports on occupational conditions. |
| Health and Safety Code, Chapter 85, Human Immunodeficiency Virus Services Act | Establishes several tasks and programs at DSHS dealing with HIV and AIDS, including the HIV Medication Program. Also contains hepatitis B prevention provisions. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 86 | Establishes the breast cancer program at DSHS. |
| Health and Safety Code, Chapter 87 | Requires DSHS to collect reports on and study birth defects. |
| Health and Safety Code, Chapter 88 | Requires DSHS to collect reports on childhood lead poisoning. |
| Health and Safety Code, Chapter 89 | Gives DSHS certain powers and responsibilities regarding tuberculosis screening in jails (but not state prisons). |
| Health and Safety Code, Chapter 90 | Establishes the osteoporosis education program at DSHS. |
| Health and Safety Code, Chapter 91 | Establishes the prostate cancer education program at DSHS. |
| Health and Safety Code, Chapter 92 | Creates an injury control and reporting system at DSHS. |
| Health and Safety Code, Chapter 98 | Establishes the Texas Health Care-Associated Infection Reporting System. |
| Health and Safety Code, Chapter 101 | Establishes the Texas Council on Alzheimer's Disease and Related Disorders, which advises DSHS. |
| Health and Safety Code, Chapter 103 | Establishes the Texas Diabetes Council. |
| Health and Safety Code, Chapter 104 | Establishes Statewide Health Coordinating Council, provides for state health planning and data collection, and designates DSHS as the state health planning and development agency for Texas. |
| Health and Safety Code, Chapter 105 | Requires DSHS to establish a comprehensive health professions resource center for the collection and analysis of educational and employment trends for health professions in the state. |
| Health and Safety Code, Chapter 108 | Relates to the Health Care Information Council, now DSHS. |
| Health and Safety Code, Chapter 113 | Establishes membership, powers, and duties of the Texas Organ, Tissue, and Eye Donor Council for which DSHS provides administrative support. |
| Health and Safety Code, Chapter 121, Local Public Health Reorganization Act | Relates to the relationship of local health departments and DSHS. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 123 | Establishes a public health extension service pilot program in Health Service Region 11, a region of the state that may be particularly vulnerable to biosecurity threats, disaster, and other emergencies. |
| Health and Safety Code, Chapter 141, Texas Youth Camp Safety and Health Act | Licenses and regulates youth camp safety for children under 18. |
| Health and Safety Code, Chapter 143, Texas Industrial Homework Act | Allows DSHS to regulate industrial homework. |
| Health and Safety Code, Chapter 144, Texas Renderer's Licensing Act | Requires that renderers be licensed and follow sanitation requirements. |
| Health and Safety Code, Chapter 145 | Authorizes DSHS to license and inspect tanning facilities and tanning devices. |
| Health and Safety Code, Chapter 146 | Authorizes DSHS to license and inspect tattoo studios. |
| Health and Safety Code, Chapter 161, Subchapter A | Relates to various requirements pertaining to immunizations, including mandate for DSHS to adopt an immunization schedule for children. Also contains language regarding claiming religious belief/conscience as an exemption from immunization requirements for children, and establishes the immunization registry. Establishes provider choice system for certain vaccines. |
| Health and Safety Code, Chapter 161, Subchapter C | Allows DSHS to conduct epidemiologic or toxicologic investigations. |
| Health and Safety Code, Chapter 161, Subchapter J | Requires DSHS to conduct tests for lead. |
| Health and Safety Code, Chapter 161, Subchapter K | Prohibits tobacco sales to minors; requires DSHS to implement. |
| Health and Safety Code, Chapter 161, Subchapter L | Relates to reporting to DSHS abuse and neglect or illegal, unprofessional, or unethical conduct in certain licensed healthcare facilities. |
| Health and Safety Code, Chapter 161, Subchapter N | Requires the Commissioner of DSHS to approve tobacco awareness programs that are court-ordered for minors. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 164, Treatment Facilities Marketing Practices Act | Relates to marketing practices by mental health and chemical dependency treatment facilities and enforcement by the state licensing agency, including DSHS. |
| Health and Safety Code, § 166.083 | Authorizes DSHS to create, per rule, a standard form for an Out-of-Hospital Do-Not-Resuscitate Order (OOH-DNR) and other rules related to OOH-DNRs. |
| Health and Safety Code, §170.002 | Provides for certification to DSHS of the abortion of a viable unborn child. |
| Health and Safety Code, Chapter 171 | Relates to DSHS enforcement authority of Woman's Right to Know Act and publication of informational materials. Requires particular information be provided before an abortion may be performed. |
| Health and Safety Code, Chapters 191, 192, 193, 194, and 195 | Provides for the administration of vital statistics by DSHS. |
| Health and Safety Code, Chapter 222 | Relates to surveys of hospitals by DSHS. |
| Health and Safety Code, Chapter 241, Texas Hospital Licensing Law | Provides for licensing and regulation of general and special hospitals by DSHS. |
| Health and Safety Code, Chapter 243, Texas Ambulatory Surgical Center Licensing Act | Provides for licensing and regulation of ambulatory surgical centers by DSHS. |
| Health and Safety Code, Chapter 244, Texas Birthing Center Licensing Act | Provides for licensing and regulation of birthing centers by DSHS. |
| Health and Safety Code, Chapter 245, Texas Abortion Facility Reporting and Licensing Act | Provides for licensing and regulation of abortion facilities by DSHS. |
| Health and Safety Code, Chapter 248, Texas Special Care Facility Licensing Act | Provides for licensing and regulation of special care facilities by DSHS. |
| Health and Safety Code, Chapter 250 | Provides for criminal background checks and nurse aide registry checks for hiring of employees and appointment of volunteers within State Hospitals. |
| Health and Safety Code, Chapter 251 | Provides for licensing and regulation of end stage renal disease facilities by DSHS. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 254 | Provides for licensing and regulation of freestanding emergency medical care facilities by DSHS. |
| Health and Safety Code, Chapter 311 | Relates to powers and duties of hospitals, hospitals reporting data to DSHS, and limited liability certification and provides DSHS with certain enforcement authority. |
| Health and Safety Code, § 312.005 | Authorizes DSHS to approve contracts regarding dental and medical education in public hospitals. |
| Health and Safety Code, Chapter 314 | Relates to DSHS approval of certain cooperative agreements among hospitals. |
| Health and Safety Code, § 321.002 | Requires agencies, including DSHS, to develop a bill of rights for inpatient mental health, chemical dependency, and comprehensive medical rehabilitation services patients. |
| Health and Safety Code, Chapter 322 | Relates to the use of restraint and seclusion in certain healthcare facilities, including mental hospitals, mental health facilities, and chemical dependency treatment facilities and requires promulgation of rules. |
| Health and Safety Code, Chapter 341 | Provides minimum standards of sanitation and health protection measures; allows DSHS to inspect general sanitation conditions, regulate swimming pools, regulate water parks, and investigate public health nuisances. |
| Health and Safety Code, Chapter 343 | Defines and regulates public health nuisances in unincorporated areas of a county. DSHS is only involved if there is no other local health authority. |
| Health and Safety Code, Chapter 345 | Regulates the manufacture and sale of new and renovated bedding. |
| Health and Safety Code, Chapter 385 | Allows DSHS to establish voluntary guidelines for indoor air quality for public schools. |
| Health and Safety Code, Chapter 401, Texas Radiation Control Act | Requires DSHS to regulate the use, user, and sources of radiation. |
| Health and Safety Code, Chapter 401, Subchapter M | Provides for licensing and regulation of laser hair removal facilities by DSHS. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 431, Texas Food Drug and Cosmetic Act | Regulates all manufacturers, re-packers, brokers, and distributors of foods, drugs, devices, and cosmetics. Regulations include the labeling and advertisement of the products. Also allows the issuance of Certificates of Free Sale for exporting purposes. |
| Health and Safety Code, Chapter 432, Food, Drug, Device and Cosmetic Salvage Act | Provides DSHS with the authority to license and regulate food, drug, device, and cosmetic salvage establishments and salvage brokers. |
| Health and Safety Code, Chapter 433 | Provides for the inspection of meat and poultry products and regulates the labeling of the products. |
| Health and Safety Code, Chapter 434 | Authorizes DSHS to regulate the production, preparation, storage, and display of bakery products intended for sale and human consumption. |
| Health and Safety Code, Chapter 435 | Provides DSHS with the authority to regulate milk and milk products produced, processed, or manufactured in Texas or imported from other states. |
| Health and Safety Code, Chapter 436, Texas Aquatic Life Act | Provides DSHS with the authority to regulate shellfish plant facilities and the harvesting, transporting, storing, handling, and packaging of shellfish. |
| Health and Safety Code, Chapter 437, Regulation of Food Service Establishments, Retail Food Stores, Mobile Food Units, and Roadside Food Vendors | Authorizes DSHS to adopt rules to regulate food service establishments, retail food stores, mobile food units, and roadside vendors in areas not regulated by a county or public health district. Requires DSHS to set minimum standards for permitting sanitation, which may be adopted by counties or public health districts for regulating these entities. If no local regulation, then DSHS regulates. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 438, Public Health Measures Relating to Food | Authorizes DSHS to regulate unpacked foods, sterilization of food service items, infected food handlers, and food service worker training. Authorizes DSHS to accredit food sanitation programs, perform examination audits of accredited programs, and publish a quarterly class schedule. |
| Health and Safety Code, Chapter 439 | Authorizes DSHS to regulate the manufacture, sale, and administration of laetrile and dimethyl sulfoxide. |
| Health and Safety Code, Chapter 440, Frozen Desserts Manufacturer Licensing Act | Provides DSHS with authority to regulate the manufacture of frozen desserts. |
| Health and Safety Code, Chapter 461 | Relates to the powers and duties of DSHS relating to alcohol and substance abuse programs. |
| Health and Safety Code, Chapter 462 | Relates to the voluntary and involuntary treatment of chemically dependent persons. |
| Health and Safety Code, Chapter 464 | Provides for DSHS licensing and regulation of chemical dependency treatment facilities and registration of faith-based exempt chemical dependency treatment programs. |
| Health and Safety Code, Chapter 466 | Gives DSHS the authority to license and regulate narcotic drug treatment programs. |
| Health and Safety Code, Chapter 467 | Authorizes peer assistance programs to be established under minimum criteria established by DSHS guidance. |
| Health and Safety Code, Chapter 469 | Relates to drug court programs. |
| Health and Safety Code, Chapter 481, Texas Controlled Substances Act | Gives DSHS the authority to schedule, reschedule, and de-schedule controlled substances and to regulate the manufacture, distribution, and dispensing of controlled substances, chemical precursors, and chemical laboratory apparatus. |
| Health and Safety Code, Chapter 482 | Provides criminal penalties for unlawful delivery or manufacture of simulated controlled substances (“look-alike” drugs). |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 483, Dangerous Drug Act | Sets out who may possess or distribute a dangerous drug and allows the Commissioner of DSHS to limit drugs that are misused and abused to the prescription of a practitioner. Outlines the duties of pharmacists, practitioners, and other persons in the dispensing of dangerous drugs. |
| Health and Safety Code, Chapter 485 | Regulates the sale, delivery, and misuse of abusable volatile chemicals, glues, and aerosol paints. |
| Health and Safety Code, Chapter 486 | Establishes programs and initiatives to prevent the manufacture and use of methamphetamine; requires DSHS to implement a methamphetamine watch program for retailers of pseudoephedrine products and administer a prevention and education program for students, parents, and educators. |
| Health and Safety Code, Chapter 486 | Ensures uniform and equitable implementation and enforcement throughout the state in the regulation of over-the-counter sales of products that contain ephedrine, pseudoephedrine, or norpseudoephedrine. |
| Health and Safety Code, Chapter 501 | Regulates the use and labeling of hazardous substances, including toys and children's clothing. |
| Health and Safety Code, Chapter 502 | Requires public employers to provide information, training, and appropriate personal protective equipment to their employees who may be exposed to hazardous chemicals in their workplaces, maintain a chemical list, train employees, and provide records to DSHS regarding hazardous chemicals in the workplace. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 505, Manufacturing Facility Community Right To Know Act | Requires that operators of certain types of facilities provide emergency personnel, DSHS, and the public with information concerning hazardous chemicals at the facility to which persons may be exposed during emergency situations or as a result of proximity to the facility. |
| Health and Safety Code, Chapter 506, Public Employer Community Right to Know Act | Requires public employers to provide emergency personnel, DSHS, and the public with information concerning hazardous chemicals to which persons may be exposed during emergency situations or as a result of proximity to the facility. |
| Health and Safety Code, Chapter 507, Non-Manufacturing Facilities Community Right to Know Act | Requires employers who are not subject to Health and Safety Code, Chapters 505 or 506, to provide emergency personnel, DSHS, and the public with information concerning hazardous chemicals to which persons may be exposed during emergency situations or as a result of proximity to the facility. |
| Health and Safety Code, Chapters 531, 532, and 533 | Relates to the organization and duties of the former TDMHMR. |
| Health and Safety Code, Chapter 534 | Relates to the establishment of community centers and provision of community services. |
| Health and Safety Code, Chapter 535 | Relates to the in-home and family support program. |
| Health and Safety Code, Chapter 551 | Relates to the powers and duties related to State Hospitals. |
| Health and Safety Code, Chapter 552.001 | Designates service areas of State Hospitals. |
| Health and Safety Code, Chapter 552.011 – 552.019 | Relates to the support of indigent and non-indigent patients in State Hospitals. |
| Health and Safety Code, Chapter 554.001 – 554.002 | Provides admission criteria for Waco Center for Youth. |
| Health and Safety Code, Chapter 571 | Relates to assessment of administrative penalties by DSHS against private mental facilities. Also provides definitions and general provisions applicable to the operations of State Hospitals. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapters 571, 572, 573, 574, 575, and 576<br>Texas Mental Health Code | Provides persons having severe mental illness access to humane care and treatment. |
| Health and Safety Code, Chapter 577 | Provides for licensing and regulation of private mental facilities by DSHS. |
| Health and Safety Code, Chapter 578 | Relates to the use and reporting of electroconvulsive therapy. |
| Health and Safety Code, Chapter 611 | Relates to the confidentiality of mental health records. |
| Health and Safety Code, Chapter 612 | Relates to the Interstate Compact on Mental Health. |
| Health and Safety Code, § 614.001 – 614.020 | Establishes the Texas Correction Office on Offenders with Medical and Mental Impairments. |
| Health and Safety Code, § 615.001 | Relates to county responsibility for support of persons with mental illness. |
| Health and Safety Code, § 615.002 | Relates to access to mental health records by protection and advocacy system. |
| Health and Safety Code, Chapter 671, Subchapter A | Relates to the pronouncement of death by employees of healthcare facilities pursuant to rules adopted by the Board of Health. |
| Health and Safety Code, § 673.004 | Requires DSHS to develop a model program concerning sudden infant death syndrome. |
| Health and Safety Code, § 674.001 | Relates to fetal and infant mortality review. |
| Health and Safety Code, Chapter 692A,<br>Uniform Anatomical Gift Act | Establishes the operation of the Glenda Dawson Donate Life-Texas Registry and DSHS educational program. |
| Health and Safety Code, Chapter 751,<br>Texas Mass Gathering Act | Requires that mass gatherings be conducted in accordance with minimum standards of health and sanitation prescribed by DSHS. |
| Health and Safety Code, Chapter 757 | Provides that DSHS may adopt stricter rules for design and construction of pool yard enclosures. |
| Health and Safety Code, § 756.061 | Provides for inspecting of playgrounds (youth camps) and day cares inspected by agreement with the Department of Family and Protective Services (DFPS). |
| Health and Safety Code, Chapter 768 | Relates to the safety of children who participate in rodeos. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Health and Safety Code, Chapter 773, Emergency Medical Services Act | Provides for the regulation of emergency medical services (EMS); licensing of EMS ambulance providers; certification and licensing of EMS personnel, EMS information operators, EMS instructors, and course coordinators; approval of EMS education and training programs; licensing of EMS first responder organizations; and designating of trauma facilities and trauma care systems. |
| Health and Safety Code, Chapter 777 | Governs the relationship of DSHS and regional poison control centers. |
| Health and Safety Code, Chapter 823 | Makes DSHS partially responsible for the regulation of animal shelters. |
| Health and Safety Code, Chapter 824 | Makes DSHS partially responsible for the regulation of circuses, carnivals, and zoos. |
| Health and Safety Code, Chapter 826, Rabies Control Act of 1981 | Makes DSHS partially responsible for the control of rabies. |
| Health and Safety Code, Chapter 827 | Makes DSHS responsible for the registration of riding stables. |
| Health and Safety Code, Chapter 841 | Establishes the Civil Commitment of Sexually Violent Predators Act and requires the Council on Sex Offender Treatment to provide appropriate and necessary treatment and supervision through the case management system. |
| Health and Safety Code, Chapter 1001 | Establishes the powers and duties of DSHS and creates the State Health Services Council. |
| Human Resources Code, Chapter 42.043 | Regards immunizations in certain facilities providing childcare services. |
| Human Resources Code, Chapter 48 | Relates to investigation of abuse, neglect, or exploitation of elderly or disabled persons in facilities licensed or operated by DSHS. |
| Occupations Code, Chapter 110 | Provides for the licensing and regulation of sex offender treatment providers by the Council on Sex Offender Treatment. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Occupations Code, § 157.052 | Authorizes DSHS to designate sites serving medically underserved populations to use advanced nurse practitioners and physician assistants. |
| Occupations Code, Chapter 203, Texas Midwifery Act | Establishes the Texas Midwifery Board and regulates the professional activities of persons who practice midwifery. |
| Occupations Code, Chapter 352 | Provides for the registration and regulation of registered dispensing opticians and registered spectacle dispensers by DSHS. |
| Occupations Code, Chapter 353 | Provides that DSHS will issue contact lens dispensing permits and regulate the practice of contact lens dispensing in cooperation with other agencies. |
| Occupations Code, Chapter 401 | Provides for the licensing and regulation of speech language pathologists and audiologists by the State Board of Examiners of Speech-Language Pathology and Audiology. DSHS provides personnel and facilities to accomplish this law. |
| Occupations Code, Chapter 402 | Provides for the licensing and regulation of fitters and dispensers of hearing instruments by the State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments. DSHS provides personnel and facilities to accomplish this law. |
| Occupations Code, Chapter 403 | Provides for licensing and regulation of dyslexia practitioners and dyslexia therapists by DSHS. |
| Occupations Code, Chapter 451 | Provides for the licensing and regulation of athletic trainers by the Advisory Board of Athletic Trainers. DSHS provides personnel and facilities to accomplish this law. |
| Occupations Code, Chapter 455 | Provides for the registration and regulation of massage therapists by DSHS. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Occupations Code, Chapter 502 | Provides for the licensing and regulation of marriage and family therapists by the Texas State Board of Examiners of Marriage and Family Therapists. DSHS provides personnel and facilities to accomplish this law. |
| Occupations Code, Chapter 503 | Provides for the licensing and regulation of professional counselors by the Texas State Board of Examiners of Professional Counselors. DSHS provides personnel and facilities to accomplish this law. |
| Occupations Code, Chapter 504 | Provides for DSHS regulation and applicable registration, certification, licensing, or approval of chemical dependency counselors; registration of counselor interns and clinical training institutions; and certification of certified clinical supervisors and peer assistance programs for chemical dependency counselors. Provides for DSHS funding of peer assistance program. |
| Occupations Code, Chapter 505, Social Work Practice Act | Provides for the licensing and regulation of social workers by the Texas State Board of Social Worker Examiners. DSHS provides personnel and facilities to accomplish this law. |
| Occupations Code, Chapter 601 | Provides for the certification and regulation of medical radiological technologists by DSHS. |
| Occupations Code, Chapter 602 | Provides for the licensing and regulation of medical physicists by the Texas Board of Licensure for Professional Medical Physicists. DSHS provides personnel and facilities to accomplish this law. |
| Occupations Code, Chapter 603 | Provides for the licensing and regulation of perfusionists. |
| Occupations Code, Chapter 604 | Provides for the certification and regulation of respiratory care practitioners by DSHS. |
| Occupations Code, Chapter 605 | Provides for the licensing and regulation of orthotists and prosthetists by the Texas Board of Orthotics and Prosthetics. DSHS provides personnel and facilities to accomplish this law. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Occupations Code, Chapter 701 | Provides for the licensing and regulation of dietitians by the State Board of Examiners of Dietitians. DSHS provides personnel and facilities to accomplish this law. |
| Occupations Code, Chapter 1702 | Provides for the licensing and regulation of businesses and individuals that sell and/or install personal emergency response systems. |
| Occupations Code, Chapter 1952 | Provides for the registration of code enforcement officers by DSHS and reserves the use of the title code enforcement officer to such registrants. |
| Occupations Code, Chapter 1953 | Provides for the registration of sanitarians by DSHS and reserves the use of the title sanitarian to such registrants. |
| Occupations Code, Chapter 1954, Texas Asbestos Health Protection Act | Provides DSHS with the statutory authority to regulate the handling of asbestos and to license persons who work with asbestos. |
| Occupations Code, Chapter 1955 | Provides for regulation relating to safe removal of lead-based paint. |
| Occupations Code, Chapter 1958 | Provides for licensing of mold assessors, remediators, and labs. |
| Penal Code, § 38.15 | Criminalizes interference with a person who is assessing, enacting, or enforcing public health, environmental, radiation, or safety measures for the state. |
| Transportation Code, § 455.0015 | Provides for DSHS to contract with Texas Department of Transportation for client transportation services. |
| Transportation Code, § 521.374 - 521.377 | Provides for DSHS approval and oversight of educational program for convicted drug offenders. |
| Water Code, §§ 5.013 and 7.002 | Enables and circumscribes the Texas Commission on Environmental Quality authority over medical waste disposal, in collaboration with DSHS. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Water Code, § 17.933 | Authorizes DSHS to make public health nuisance determinations for purposes of the Texas Water Development Board's Economically Distressed Areas Program. |
| Constitution Article I, Section 15 | Relates to the right of trial by jury. |
| Constitution Article I, Section 15a | Relates to the commitment of persons of unsound mind. |
| Constitution Article 9, Section 13 | Relates to the participation of political subdivisions in mental health or public health services. |
| Constitution Article 16, Section 6 | Relates to state participation in programs for mentally handicapped. |
| Acts 1991, 72nd Legislature, First Called Session, Chapter 15 (H.B. 7) | Establishes HHSC; relates to the transfer of certain programs from one HHS agency to another; creates the Department of Public Health. |
| Acts 1993, 73rd Legislature, Chapter 747 (H.B. 1510) | Relates to transfer of programs between HHS agencies, repealed legislation for Department of Public Health. |
| Acts 1995, 74th Legislature, Chapter 6 (S.B. 509) | Clarifies authority of HHSC to delegate operation of portions of Medicaid program to HHS agencies. |
| Acts 1999, 76th Legislature, Chapter 264 (H.B. 1748) | Relates to construction of Texas Center for Infectious Diseases. |
| Acts 1999, 76th Legislature, Chapter 1106 (H.B. 3504), as amended by S.B. 815, 79th Legislature, 2005. | Relates to construction for South Texas Health Care System. |
| 8 U.S.C. § 1522(b)(5) | Relates to federal grants for refugee health screening. |
| 15 U.S.C. § 1191, *et seq.*, Federal Flammable Fabrics Act | Sets standards for flammability for bedding. |
| 15 U.S.C. § 1261, *et seq.*, Federal Hazardous Substances Act | Sets definitions for hazardous substances used in Health and Safety Code, Chapter 501. |
| 15 U.S.C. §§ 2641-2656, Toxic Substances Control Act, Ch. 53, Subchapter II, Asbestos Hazard Emergency Response | Provides requirements for management of asbestos in schools that are enforced under Occupations Code, Chapter 1954. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| 15 U.S.C. §§ 2681-2692, Toxic Substances Control Act, Ch. 53, Subchapter IV, Lead Exposure Reduction | Provides requirements for lead abatement contractor training and certification that are the basis for the state program requirements under Occupations Code, Chapter 1955. |
| 15 U.S.C. Ch. 106, §§ 8001-8008, Virginia Graeme Baker Pool and Spa Safety Act | Provides suction device standards for which DSHS must adopt standards at least as stringent under Health and Safety Code, § 341.0645. |
| 21 U.S.C. § 301, *et seq.*,<br>Federal Food, Drug, and Cosmetic Act<br>Animal Drug Amendments of 1968<br>Controlled Substances Act<br>Orphan Drug Act and Amendments of 1985 & 1988<br>Drug Price Competition and Patent Term Restoration Act of 1984<br>Prescription Drug Marketing Act of 1987<br>Prescription Drug Amendment of 1992<br>Prescription Drug User Fee Act of 1992<br>Anabolic Steroids Control Act of 1990<br>Generic Drug Enforcement Act of 1992<br>Medical Device Amendments of 1976 and 1992<br>Safe Medical Devices Act of 1990 | Establishes federal requirements that DSHS has adopted by reference or uses as models for regulating the safety of food, drugs, and cosmetics. |
| 21 U.S.C. § 451, *et seq.*,<br>Federal Poultry Inspection Act | Provides standards that DSHS follows in inspecting poultry products. |
| 21 U.S.C. § 601, *et seq.*,<br>Federal Meat Inspection Act | Provides standards that DSHS follows in inspecting meat products. |
| 29 U.S.C. Ch. 15, §§ 651 – 678,<br>Occupational Health and Safety Act of 1970 | Sets definitions for hazardous chemicals used in Health and Safety Code, Chapter 502 |
| 42 U.S.C. §§ 201, 246, 300e-4, 300k, 300k-1, 300 k-2, 300k-3, 300l, 300l-1, 300m, 300q, 300q-2, 300v, 300s, 300s-6, 300t, 300t-11, 300t-13, 300t-14, 1396b,<br>(P.L. 93-641, P.L. 96-79),<br>National Health Planning and Resources Development Act of 1974 and the Health | Provides for the establishment of a state health planning and development agency in each state for effective health planning and resources development programs. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| Planning and Resources Development Amendments of 1979 | |
| 42 U.S.C. § 243 | Sets the standards that all states with a shellfish program must follow. |
| 42 U.S.C. § 247a | Establishes family support groups for Alzheimer's patients. |
| 42 U.S.C. § 247b | Authorizes grants on prevention and education on tuberculosis. |
| 42 U.S.C. § 247b-1 | Establishes lead poisoning prevention and education grants. |
| 42 U.S.C. § 247b-3 | Establishes grants on education, technology assessment, and epidemiology regarding lead poisoning. |
| 42 U.S.C. § 247b-4 | Encourages states to collect and analyze epidemiological data on birth defects. |
| 42 U.S.C. § 247b-5 | Provides grants for preventive health measures with regard to prostate cancer. |
| 42 U.S.C. § 247b-6 | Provides grants for preventive health services with regard to tuberculosis. |
| 42 U.S.C. § 247c to c-1 | Establishes STD prevention and control projects. |
| 42 U.S.C. §§ 262 and 263 | Regulates biological products/clinical laboratories. |
| 42 U.S.C. § 263a | Provides for the certification of laboratories. |
| 42 U.S.C. § 280 to 280b-3 | Provides for control of and research into injuries. |
| 42 U.S.C. §§ 280c-3 to 280c-5 | Establishes grants for demonstration projects with respect to Alzheimer's disease. |
| 42 U.S.C. §§ 280e to 280e-4 | Establishes a national program of cancer registries. |
| 42 U.S.C. §§ 285c to 285c-7 | Creates the National Institute of Diabetes. |
| 42 U.S.C. §§ 285e to 285e-8 | Establishes the National Institute on Aging with various functions relating to Alzheimer's disease. |
| 42 U.S.C. §§ 285l to 285l-1 | Establishes a national institute of environmental health sciences. |
| 42 U.S.C. § 290dd-2 | Relates to the confidentiality of substance abuse records. |

| Department of State Health Services<br>Exhibit 12: Statutes/Attorney General Opinions | |
|---|---|
| **Statutes** | |
| **Citation/Title** | **Authority/Impact on Agency** |
| 42 U.S.C. § 300a | Authorizes federal grants to state health authorities to assist in planning, establishing, maintaining, coordinating, and evaluating family planning services. |
| 42 U.S.C. §§ 300aa-1 to 300aa-34 | Establishes the National Vaccine Program and the National Vaccine Injury Compensation Program. |
| 42 U.S.C. §§ 300dd-21 to 300dd-41 | Establishes grants for health services with respect to AIDS. |
| 42 U.S.C. §§ 300ee to 300ee-34 | Establishes grants for AIDS prevention. |
| 42 U.S.C. §§ 300ff to 300ff-111,<br>The Ryan White Comprehensive AIDS Resources Act of 1991 | Establishes grants for services to individuals afflicted with HIV and AIDS. |
| 42 U.S.C. §§ 300g to 300j-26 | Provides for the safety of public water systems. |

| Attorney General Opinions | | |
|---|---|---|
| **OAG Opinion No.** | **Year** | **Impact on Agency** |
| **GA-877** | **2011** | Responsibility for an individual who is the subject of an emergency detention order. |
| **GA-803** | **2010** | Whether a facility must have a license to perform medical abortions, and whether drugs to induce an abortion must be ingested in the presence of the prescribing physician. |
| **GA-753** | **2009** | Whether a peace officer who has taken a person into custody under Chapter 573, Texas Health and Safety Code, may be required to transport that individual to a medical facility for evaluation prior to taking the person to a mental health facility. |
| **GA-729** | **2009** | Whether DSHS has the authority to enforce state asbestos regulations against municipalities. |

**B. Provide a summary of recent legislation regarding your agency by filling in the chart below or attaching information already available in an agency-developed format. Briefly summarize the key provisions. For bills that did not pass, briefly explain the key provisions and issues that resulted in failure of the bill to pass (e.g., opposition to a new fee, or high cost of implementation). Place an asterisk next to bills that could have a major impact on the agency.**

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
|---|---|---|
| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| *H.B. 15 | Kolkhorst | • Requires the Health and Human Services Commission (HHSC) to assign levels of care designations to each hospital based on neonatal and maternal services provided pursuant to rules adopted no later than March 1, 2017.<br>• Links designations to Medicaid reimbursement.<br>• The Neonatal Intensive Care Unit designation process will be advised by a newly created Perinatal Advisory Council. The Executive Commissioner appoints members to the council. |
| *H.B. 740 | Crownover | • Allows DSHS to authorize a newborn screening test for critical congenital heart disease (CCHD). DSHS must consider cost implications for providers.<br>• Requires birthing facilities to perform any authorized CCHD screening prior to a newborn's discharge, except in detailed instances.<br>• Specifies that parents may decline the screening for their newborn.<br>• Increases the composition of the Newborn Screening Advisory Committee.<br>• Requires the Committee to advise DSHS on each disorder included in the core and secondary conditions under the Recommended Uniform Screening Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and to review the necessity of requiring additional screening tests. |
| *H.B. 746 | Ashby | • Places limitations on civil liabilities for volunteer medical and veterinary care practitioners during declared |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
|---|---|---|
| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| | | emergencies, to allow them to be deployed and practice during disasters within Texas scope of practice laws.<br>• Requires DSHS to administer the volunteer health practitioner registration system and to ensure a criminal background check and verification of licensing and registration in the volunteer's home state. |
| H.B. 970 | E. Rodriguez | • Expands the types of foods that a cottage food operation may produce and the locations at which such an operation can sell its products.<br>• Establishes additional regulations regarding the sale of cottage food products.<br>• Amends current law relating to a local government's authority to regulate cottage food production operations.<br>• Prevents municipal zoning ordinances from prohibiting use of a home for cottage food production. |
| *H.B. 1023 | Burkett | • Requires HHSC to use existing information and data available through state and nongovernmental entities, and through the Statewide Health Coordinating Council, to complete a report on mental health workforce shortages in Texas.<br>• HHSC may delegate this report to another health and human services agency.<br>• Report must include recommendations for improving the mental health workforce, and it must account for the feasibility, costs and benefits, and any needed legislative changes for each recommendation. |
| H.B. 1081 | M. Gonzalez | • Requires that the Texas Animal Health Commission conduct a study regarding the current risk level of bovine tuberculosis in El Paso County, which is currently designated as a movement restriction zone.<br>• DSHS has been prohibited from issuing a permit to dairy producers located in the movement restriction zone for bovine tuberculosis since 2001. |
| H.B. 1376 | Kolkhorst | • Requires hospital-owned-and-operated freestanding emergency medical facilities that bill patients at emergency room rates to advertise as emergency rooms. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
|---|---|---|
| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| | | • Requires these facilities to notify prospective patients that the facility is an emergency room and charges rates comparable to a hospital emergency room. |
| H.B. 1382 | Simpson | • Prohibits the regulation of food sold to consumers at farms or farmers' markets.<br>• Provides for sanitary conditions for the preparation and distribution of food at a farm or farmers' market.<br>• Prohibits the sale of or provision of samples of raw milk or raw milk products at a farmers' market. |
| *H.B.1392 | S. King | • Requires DSHS to provide a reasonable and substantial response to inquiries about food regulations within 30 days.<br>• Requires DSHS to provide an official written determination regarding the applicability of a food regulation to a specific circumstance within 30 days.<br>• Prohibits an inspector from issuing a citation to a person for a violation of a food regulation if the person provides the inspector with an official determination that contradicts the opinion of the inspector.<br>• Requires HHSC to review periodically food rules and regulations to ensure the rules are consistent and clearly communicated to the public. |
| *H.B. 1394 | S. King | • Subjects Texas Health Care Information Collection (THCIC) to Sunset Advisory Commission review during the upcoming interim.<br>• The review should consider whether THCIC meets legislative intent, maintains privacy and security, and whether the data collected is limited to that which is relevant to statutory purposes.<br>• THCIC is abolished, effective September 1, 2015, unless continued by the Legislature. |
| H.B. 1396 | S. King | • Requires DSHS and the Department of Family and Protective Services (DFPS) to perform a one-time study on whether either agency keeps specific alcohol and controlled substance statistics related to children, their parents, and DFPS investigations. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
|---|---|---|
| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| | | • If not, the agencies must determine which of the agencies is best suited to collect this information with the least expense, and at what cost.<br>• The study must be performed within existing resources, and is due November 1, 2014. |
| H.B. 1690 | Fletcher | • Allows peace officers, including sheriffs and constables, to use reasonable force to secure a person or persons subject to a control order for infectious disease to a group, property, or quarantine area, and except as directed by DSHS or local health department, prevent them from leaving or joining the group.<br>• Authorizes judges to direct a peace officer to prevent a person involuntarily in the Texas Center for Infectious Diseases (TCID) or a designated facility from leaving the facility.<br>• Allows judges to require an emergency medical services (EMS) provider to transport a person or persons subject to a protective custody or temporary detention order to TCID or a designated facility. |
| H.B. 1903 | Eiland | • Abolishes the Oyster Advisory Committee.<br>• Modifies the use of fees and penalties related to oyster sales and allows the funds to contribute to the support of the oyster shell recovery and replacement program operated under the Parks and Wildlife Code.<br>• The Comptroller will allocate $100,000 each fiscal year from amounts remaining in the General Revenue-Dedicated Account 5022 Oyster Sales to Texas A&M University at Galveston for studying and analyzing organisms that may be associated with human illness and transmitted through oyster consumption.<br>• Removes the requirement that funds in the oyster sales account shall first be appropriated for public health activities; funds will now be used for the oyster shell recovery and replacement program, for the Texas A&M activities, and for administrative costs incurred by the Comptroller. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
|---|---|---|
| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| *H.B. 2392 | Menendez | • Adds veterans' mental health to DSHS' specific responsibilities in statute.<br>• A resulting program must include: peer-to-peer counseling; access to licensed mental health practitioners; DSHS-approved training for peers; technical assistance for volunteer coordinators and peers; grants to regional and local organizations providing relevant services; recruitment, retention and screening of community-based therapists; suicide prevention for volunteer coordinators and peers; and veteran jail diversion services, including veterans courts.<br>• Requires that grants to emphasize direct services to veterans, leverage local resources, and increase the capacity of the veterans' mental health program.<br>• Senate Bill 1 appropriates $4 million in General Revenue for this purpose.<br>• An annual report is due by December 1 of each year. |
| H.B. 3105 | Morrison | • Repeals a section of the Insurance Code that required individual accident and health policies to contain the following statement: "The insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless the narcotic is administered on the advice of a physician."<br>• This makes coverage of these situations optional. |
| *H.B. 3253 | Zerwas | • Allows the DSHS Vital Statistics Unit (VSU) to notate on a death certificate of a person younger than 55 years old who was born in Texas to reduce potential for fraud.<br>• Allows faculty members at medical schools access to confidential birth certificate information if the Institutional Review Board and DSHS approve the research plan. |
| H.B. 3285 | Thompson | • Allows DSHS to receive information about deaths resulting from healthcare-associated infections (HAIs) prior to discharge from healthcare facilities required to report HAI infections, and requires those facilities to report HAI-caused deaths as part of HAI reporting. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
|---|---|---|
| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| | | • Requires DSHS post this information on the DSHS HAI data site. |
| H.B. 3433 | Fletcher | • Requires the DSHS Medical Advisory Board, if requested by the Department of Public Safety, to determine whether an applicant for or a holder of a commission as a security officer is capable of exercising sound judgment with respect to the proper use and storage of a handgun. |
| H.B. 3556 | Kolkhorst | • Adds a licensure provision requiring EMS provider applicants to hold a letter of approval issued from a local government entity.<br>• Requires emergency ambulance transportation providers to supply DSHS with letters of credit and a surety bond.<br>• Requires certain providers to provide a surety bond to HHSC.<br>• Requires DSHS to submit a report no later than December 1 of even numbered years to the Office of the Governor and the Legislature on license and regulatory actions related to EMS providers. |
| *H.B. 3793 | Coleman | • Expands the services required of local mental health authorities (LMHAs) and the disorders to which they can be applied, to the extent feasible using funds appropriated from the Texas Health Care Transformation and Quality Improvement Program 1115 waiver.<br>• Requires DSHS and HHSC to collaborate on a plan on the allocation of outpatient and residential mental health services. The plan is due December 31, 2013.<br>• The plan must include:<br>  ○ a determination of the need for outpatient mental health services for both voluntary and committed patients;<br>  ○ a determination of the number of inpatient beds needed to serve both populations;<br>  ○ a plan for the allocation of sufficient funds to meet the needs of the two populations for outpatient and inpatient services; and<br>  ○ a process to address and develop the accessibility and |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| | | availability of sufficient outpatient and inpatient services for the two populations.<br>• A follow up report is due by December 1, 2014, and must include an initial version of the plan, the status of its implementation, and the effect on services.<br>• Requires DSHS to inform courts of all commitment options, including jail diversion and community-based options.<br>• Requires DSHS to award grants, to the degree funds are available, to LMHAs to contract with DSHS-approved entities to train LMHA employees or contractors as mental health first aid trainers. Statute caps these grant amounts.<br>• Additional grants will allow LMHAs to provide mental health first aid training to educators at no cost to the educator, for helping educators assist individuals experiencing mental health crises. Statute caps these grant amounts. |
| *S.B. 8 | Nelson | • Puts in place new requirements for the licensing and regulation of EMS providers.<br>• Provides that license applicants must:<br>  ○ possess sufficient professional experience and qualifications to provide services;<br>  ○ not have been excluded from participation in the state Medicaid program;<br>  ○ hold a letter of approval issued by the applicant's local municipal government or commissioner's court that verifies the applicant is applying to provide services to the local jurisdiction;<br>  ○ employ a medical director;<br>  ○ provide DSHS with a letter of credit; and<br>  ○ submit for approval by DSHS the name and contact information of the provider's administrator of record, who must the meet new requirements specified in S.B. 8.<br>• Provides the grounds for which an EMS provider license can be suspended, revoked, or denied.<br>• EMS providers directly operated by a governmental entity |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| | | are exempted from certain requirements.<br>• DSHS must submit a report no later than December 1 of even numbered years to the Legislature on EMS provider license and regulatory actions.<br>• Places a moratorium on the issuance of a new EMS provider license for the period beginning on September 1, 2013 and ending on August 31, 2014.<br>• Requires HHSC, DSHS, and the Texas Medical Board to:<br>  ○ conduct a thorough review of and solicit stakeholder input regarding the use of non-emergent services provided by ambulance providers under Medicaid; and<br>  ○ make recommendations to the Legislature regarding suggested changes to the law that would reduce the incidence of and opportunities for fraud, waste, and abuse by January 1, 2014.<br>• Requires HHSC, DSHS, and the Texas Medical Board to:<br>  ○ conduct a thorough review of and solicit stakeholder input regarding the laws and policies related to the licensure of nonemergency transportation providers; and<br>  ○ before January 1, 2014, make recommendations to the Legislature regarding suggested changes to the law that would reduce the incidence of and opportunities for fraud, waste, and abuse. |
| *S.B. 58 | Nelson | • Requires HHSC, to the greatest extent possible, to integrate behavioral health services into the Medicaid managed care program.<br>• Exempts the NorthSTAR service area.<br>• Requires HHSC and DSHS to establish a Behavioral Health Integration Advisory Committee to assist in this process.<br>• Creates a community collaborative grant program to serve persons experiencing homelessness and mental health issues. Appropriates $25 million in S.B. 1 for this purpose. |
| *S.B. 62 | Nelson | • Limits the applicability of the bacterial meningitis vaccine requirement for entering college students to those |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| | | students 21 years old and younger. Previously, the requirement applied to students 29 years old and younger.<br>• DSHS must implement a secure web-based process for exemptions for reasons of conscience at public junior colleges.<br>• DSHS must annually report to the Legislature the number of exemption forms requested through the electronic process. |
| S.B. 63 | Nelson | • Allows a child to consent to the child's own immunization if the child is pregnant or the child is a parent, with custody, of a child.<br>• This allowance is limited to childhood vaccines recommended by the Centers for Disease Control and Prevention.<br>• A written statement by the child would suffice as proof for the vaccine provider. |
| S.B. 64 | Nelson | • Requires licensed childcare facilities to adopt vaccine-preventable diseases policies for its employees.<br>• Policies must include consideration of employees' routine and direct exposure to the children, and base which vaccines are required on the amount of risk posed.<br>• Requires a method of exemption for reasons of conscience. |
| S.B. 66 | Nelson | • Adds members with expertise in EMS and family violence victim services to the State Child Fatality Review Team (SCFRT) and reconciles statutory language on the report to SCFRT practices.<br>• Changes SCFRT reporting requirements from an annual report to a biennial report, due April 1 of each even-numbered year.<br>• Creates the Protect Our Kids Commission to study the relationship between child protective services and child welfare services and the rate of child abuse and neglect fatalities.<br>• Requires commission to submit a report containing findings and recommendations no later than December 1, 2015. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| *S.B. 126 | Nelson | • Requires DSHS to create a Mental Health and Substance Abuse Public Reporting System.<br>  ○ The system must allow external users to compare the performance, output and outcomes of community centers, Medicaid managed care pilot programs that provide mental health services (NorthSTAR), and entities that contract with the State to provide substance abuse services.<br>  ○ DSHS must post performance, output and outcome measures on the DSHS website on a quarterly or semi-annual basis.<br>  ○ DSHS is required to submit a report to the Legislature on the establishment of the reporting system by December 1, 2014.<br>• HHSC is required to conduct a study to determine the feasibility of establishing and maintaining the public reporting system, including, to the extent possible, the cost to the State and the impact on managed care organizations and providers of collecting the data by December 1, 2014. |
| S.B. 127 | Nelson | • Requires DSHS to collaborate with the Public Health and Funding Policy Committee to create funding formulas that take into account population, population density, disease burden, social determinants of health, local efforts to prevent disease, and other relevant factors.<br>• The formulas must be complete by October 1, 2014.<br>• Requires DSHS and the Committee to evaluate the feasibility of an administrative cap on local health spending.<br>• Requires DSHS and the Committee to evaluate if public health functions can be performed by private entities or entities other than DSHS, health service regions, or local health departments (LHDs).<br>• These reports are due by October 1, 2014.<br>• Requires DSHS to create a policy to give greater flexibility to LHDs departments during public health threats. The policy must be enacted by October 1, 2014. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| S.B. 152 | Nelson | • Enacts recommendations from the Interagency Facilities Workgroup responding to the alleged abuse of young patients in the mental health system.<br>• Requires the Executive Commissioner to adopt a policy requiring the reporting of a fellow employee who is reasonably suspected of using a controlled substance.<br>• Specifies that required training of new staff at State Hospitals must include techniques for improving patient quality of life and promoting patient health and safety, and must cover the conduct expected of state employees.<br>• DSHS must ensure that all employees receive training by September 1, 2014.<br>• Requires an information management, reporting, and tracking system for each State Hospital to assist with managing serious allegations of abuse, neglect, or exploitation.<br>• Authorizes DSHS to conduct criminal history checks for individuals expected to be in direct contact with patients.<br>• Requires the Office of Inspector General to employ peace officers to assist law enforcement agencies with investigation of alleged criminal offenses at State Hospitals.<br>• Funded in S.B. 1 with $1.3 million. |
| S.B. 347 | Seliger | • Prohibits DSHS from collecting fees for the transport of waste being disposed of at the federal waste disposal facility.<br>• Allows DSHS to use funds in the General Revenue-Dedicated Perpetual Care Account No. 5096 for first responder training in counties with designated radioactive waste transportation routes.<br>• Removes the $500,000 cap for fees collected and deposited into the Perpetual Care Account No. 5096.<br>• Provides that the existing Perpetual Care Account No. 5096 be exclusively for use by DSHS and the newly created account would be for the exclusive use of the Texas Commission on Environmental Quality (TCEQ).<br>• Suspends DSHS and TCEQ collection of low-level |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| | | radioactive waste license and transportation fees when the combined balance of the Environmental Radiation and Perpetual Care Account and the Perpetual Care Account No. 5096 reaches $100 million. Reinstates fees when the balance reaches $50 million.<br>• Requires TCEQ and DSHS to update the memorandum of understanding regarding the regulation and oversight of radioactive materials and sources of radiation by January 1, 2014. |
| *S.B. 495 | Huffman | • Creates a multidisciplinary task force to study maternal mortality and morbidity cases in Texas.<br>• DSHS is responsible for administering the Maternal Mortality and Morbidity Task Force and for preparing a de-identified, statistically significant cross-section of mortality and morbidity cases for the task force's review.<br>• DSHS and the task force must submit a joint report of the task force's findings and recommendations to the Governor and Legislature no later than September 1 of each even-numbered year. |
| S.B. 793 | Deuell | • Removes the term "transfer agreement" from the newborn hearing screening law, thus allowing birthing centers or other facilities to use referrals instead of a formal transfer agreement to fulfill their obligation under the law.<br>• The bill specifies the entities and practitioners that facilities may refer parents to for a newborn's hearing screening. |
| S.B. 872 | Deuell | • Allows counties, regardless of their application, documentation, and verification procedures or their eligibility standards, to credit Intergovernmental Transfers toward eligibility for state assistance for indigent care if the transfer was made to provide health care.<br>• Capped at four percent of the counties' General Revenue tax levy. |
| S.B. 944 | Nelson | • Requires mental health service units of hospitals licensed in Texas to check the nurse aide registry and run criminal history checks for employees and applicants for employment. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| S.B. 945 | Nelson | • Requires hospitals to adopt a policy requiring a healthcare provider providing direct patient care at the hospital to wear a photo identification badge during all patient encounters, unless precluded by isolation or sterilization protocols. |
| *S.B. 1057 | Nelson | • Prohibits DSHS from providing health or mental health benefits, services, or assistance without an attestation form indicating that the applicant has no access to those services under a private healthcare insurance plan.<br>• If the individual does have access to private health insurance, then the individual shall provide information and authorization for DSHS to submit a claim for reimbursement from the insurer for the benefit, service or assistance provided.<br>• DSHS must develop educational materials.<br>• DSHS may waive the prohibition of services in times of crisis or emergency if the service is deemed necessary at that time. |
| *S.B. 1185 | Huffman | • Requires DSHS to establish a mental health diversion pilot program, which will be implemented by the Harris County Judge.<br>• The county will design and test a criminal justice mental health service model that includes the following elements: low caseload management, multilevel residential services, access to integrated health, mental health and substance abuse services, benefits reacquisition services, and multiple rehabilitation services.<br>• The pilot program shall seek to give persons with mental health issues access to clinical, housing, and welfare services in the first weeks after release from jail.<br>• The County Judge must provide resources to serve no less than 200 individuals, but shall endeavor to serve annually between 500 and 600 individuals.<br>• Authorizes DSHS to inspect the program and requires DSHS to submit an evaluation of the program by December 1, 2016. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| | | • The evaluation must include a description of the project service model, make recommendations on statewide expansion, and compare the rates of recidivism in Harris County before and after the pilot program's implementation.<br>• Senate Bill 1 provides $10 million in General Revenue for this program. |
| *S.B. 1475 | Duncan | • Requires DSHS to implement a jail-based competency restoration pilot program through a contractor in one or two counties.<br>• A contractor must be nationally certified and demonstrate experience with this type of program, or the contractor must be a local mental health authority.<br>• The pilot program must: use a multi-disciplinary approach directed toward restoring competency to stand trial; be similar to clinical treatment at inpatient competency restoration programs; employ or contract for at least one psychiatrist; have a staff-to-patient ration of at least 3.7:1; and provide weekly treatment similar to an inpatient program.<br>• Participating counties must ensure the safety of participating defendants.<br>• Senate Bill 1 appropriates $3.05 million in General Revenue for this program. A report on the program is due on December 1, 2016.<br>• These provisions expire on September 1, 2017. |
| S.B. 1815 | Zaffirini | • Removes the responsibility of DSHS to contract with nonprofit organizations to maintain the Glenda Dawson Donate Texas-Life Registry.<br>• Funding will now flow directly to Organ Procurement Organizations. |
| S.B. 1836 | Deuell | • Requires the DSHS VSU to modify its paper and electronic application forms for birth, marriage, and divorce records.<br>• Paper application and electronic request mechanisms (Texas.gov) must include a checkbox for customers to indicate that they wish to donate $5.00 to promote healthy |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Enacted – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions** |
| | | early childhood by supporting the Texas Home Visiting Program.<br>• Also requires VSU to modify the Application for Marriage License form to include a checkbox for applicants to indicate that they wish to donate $5.00 to promote healthy early childhood by supporting the Texas Home Visiting Program administered by the HHSC Office of Early Childhood Coordination. |
| *H.B. 2 (Second Called Session) | Laubenberg/ Burkett/ Harper-Brown/ G. Bonnen/ P. King | • Requires abortion facilities to reach the standards required of ambulatory surgical centers by September 1, 2014.<br>• Adds probable post-fertilization age to required annual reports from abortion facilities. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Not Passed – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions/Reason the Bill Did Not Pass** |
| H.B. 46 | Crownover | • Would authorize a person who holds a permit to sell raw milk or raw milk products at the permit holder's place of business, the consumer's residence, or a farmers' market.<br>• Opposition from industry/public health groups who felt it was contrary to public health. |
| H.B. 772 | Howard | • Would change ImmTrac from an opt-in registry, meaning a person's immunization information is not retained in the process unless the person or their legally authorized representative consents, to an opt-out registry, meaning that the information would be retained in the registry until there is a request for removal.<br>• Passed House but left pending in Senate committee. |
| H.B. 1393 | S. King | • Would prohibit requiring separate space from living area for home kitchens. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Not Passed – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions/Reason the Bill Did Not Pass** |
| | | • Opposition from public health groups who felt it was contrary to public health. |
| H.B. 2297/ S.B. 761 | Naishtat/ Lucio | • Would create a new licensing program at DSHS with three levels of medical laboratory professionals.<br>• Substantial opposition from medical and laboratory communities. |
| H.B. 2308 | Schaefer | • Would require physicians who perform abortions to report monthly to DSHS.<br>• Would allow DSHS to assess administrative penalties on physician who do not report.<br>• Left pending in committee. |
| H.B. 2625 | Coleman | • Would eliminate reference to serious emotional disorders for children and establish a single list of diagnoses for children and adults for resilience and disease management.<br>• Would add 10 additional disorders to list.<br>• Passed House but did not advance in the Senate; was amended into H.B.3793. |
| H.B. 3252 | Zerwas | • Would increase public release of birth and death data to 125 years after birth and 50 years after death. The timeframe is currently 75 years after date of birth.<br>• Left pending in committee. |
| H.B. 3687/ S.B. 1860 | Naishtat/ Deuell | • Would redefine services provided through the Primary Health Care Program.<br>• Would permit DSHS to authorize approved providers to charge a reasonable copayment for certain services.<br>• House Bill passed the House but did not advance in the Senate. Senate Bill left pending in committee. |
| H.B. 3705 | E. Rodriguez | • Would establish a pilot program that would double the value of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefits used to purchase produce at farmers' markets.<br>• Left pending in committee. |
| S.B. 537 | Deuell/ Campbell/ Schwertner | • Would require the minimum standards for an abortion facility to be equivalent to the minimum standards for ambulatory surgical centers.<br>• Reported out of committee but not voted on by Senate. |

| Department of State Health Services<br>Exhibit 13: 83rd Legislative Session Chart | | |
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| **Legislation Not Passed – 83rd Legislative Session** | | |
| **Bill Number** | **Author** | **Summary of Key Provisions/Reason the Bill Did Not Pass** |
| S.B. 807 | Deuell | • Would clarify that TCID has the authority to treat persons in Texas from other countries who are not residents, in limited circumstances.<br>• Commissioner would have the authority to allow TCID to track detainees pending disposition of deportation and/or asylum.<br>• Passed Senate and reported out of House committee but not voted on by House. |
| S.B. 1187 | Huffman | • Would make the court's authority to extend outpatient competency restoration orders consistent with its authority for inpatient competency restoration.<br>• Would have corrected a problem in a small number of cases in one jurisdiction.<br>• Left pending in committee. |

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# IX. MAJOR ISSUES

## A. Brief Description of Issue

**Issue 1: Should the State continue to provide certain services offered in the private sector?**

## B. Background/Discussion

Some Department of State Health Services (DSHS) programs provide services that are currently provided through the private sector.

- DSHS State Hospitals provide acute and sub-acute inpatient mental health treatment to psychiatric patients statewide. Some of these services are currently contracted through the private sector.
- DSHS laboratories conduct clinical chemistry and microbiological tests that may also be available through laboratories in the private sector.

The State Hospital system provides care to 254 counties, some of which have few inpatient options. DSHS provides care for adults, forensic patients, geriatric patients, patients with cognitive and behavioral conditions, patients with multiple disabilities (hearing impaired, visually impaired), and children/adolescents. Clinical specialties provide assessment, evaluation, and treatment, including psychiatry, nursing, social work, psychology, education/rehabilitation services, nutrition, and spiritual care. Medical and dental clinics, x-ray and laboratory services, and other consultative services provide additional clinical support. Services are paid through general revenue funds, private payment, private third-party insurance, and Medicare and Medicaid programs.

Facilities located in Austin, Big Spring, Kerrville, Vernon/Wichita Falls, El Paso, Rusk, Terrell, San Antonio, and Harlingen provide inpatient care. Another facility in the State Hospital system, Texas Center for Infectious Diseases (TCID) in San Antonio, provides specialized care that is not found elsewhere in Texas and is rare in the entire country. TCID treats Hansen's disease and tuberculosis (TB), including multi-drug resistant TB. Finally, Waco Center for Youth (WCY) provides inpatient residential treatment for children ages 12-18. While there are private facilities that offer residential care, those facilities do not always serve children with mental illnesses that are as complex and treatment resistant as those children provided with care at WCY.

The DSHS laboratories, located in Austin and Harlingen, have historically provided testing services to support public health purposes, as well as to ensure access to laboratory testing for participants in DSHS programs. The DSHS laboratories provide testing for DSHS programs such as Texas Health Steps, the Rio Grande State Center Outpatient Clinic, HIV/STD/hepatitis surveillance, TB, and vaccine preventable disease programs. Private sector laboratories conduct many of the same tests performed by the DSHS laboratories in support of these programs.

## C. Possible Solutions and Impact

### State Hospitals

Texas and other states contract for inpatient psychiatric services through the private sector. The expansion of the private beds may benefit the State in the long term. Use of private beds may occur in two ways: (1) contract for a private entity to operate a DSHS facility, or (2) contract for use of a private entity's beds.

DSHS initiated an effort to privatize one State Hospital based on the 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, DSHS, Rider 63). DSHS issued a request for proposal (RFP), and only one provider responded to the RFP. DSHS did not choose the provider because the provider was unable to demonstrate that it could provide the same level of care, particularly related to patient safety, with fewer resources than are currently provided in the State Hospital system. The prescriptive nature of the RFP, in keeping with the requirements of the rider, may have limited opportunities for contracting. For example, a future scenario might allow a contractor to increase facility capacity by 10 percent while keeping costs flat, instead of having to cut costs by 10 percent at static capacity. Still other ways to structure an RFP may exist that would yield an outcome beneficial to the State.

DSHS currently contracts with outside entities for psychiatric hospital services. This type of arrangement will continue to be advantageous in the future as the cost to maintain State Hospital facilities continues to grow. However, State Hospitals will still be a necessary adjunct to the private care facilities partially because there are currently not enough private facilities to serve all Texans needing inpatient psychiatric care. Additionally, many private facilities do not serve certain populations, such as patients with multiple disabilities, patients requiring longer-term care, patients needing forensic services, and patients with more complex psychiatric illnesses compounded by traumatic brain injury. Finally, far fewer child and adolescent psychiatric facilities are available in the state, and those serving children under age 8 are relatively rare outside of major urban areas.

A request for information could provide information on options for using the private sector in delivering psychiatric hospital services. Before expansion of private beds, DSHS will need to analyze the requirement that those private hospitals comply with the Continuity-of-Care rule in the Texas Administrative Code and other rules applicable to State Hospitals.

### Laboratories

Some DSHS programs have considered contracting with private laboratories for certain testing services; however, such changes could impact response times and communication. When outbreaks occur, the DSHS laboratories work with the programs to ensure that specimens associated with the outbreak are given priority testing. If there is a public health risk, DSHS laboratory staff work beyond regular business hours to perform the testing. In addition, DSHS

program staff may communicate directly with testing staff regarding results and additional testing to support the investigation. These types of support are not typically available from private sector laboratories.

Currently, the DSHS Austin laboratory is a sole-source provider for laboratory specimens for initial lead screening and for chlamydia/gonorrhea testing as part of the Texas Health Steps program. If another DSHS program contracts out for chlamydia/gonorrhea testing, the DSHS laboratory may not be able to provide this test for the Texas Health Steps program, as it may no longer be financially feasible. DSHS would need to work with the Texas Health Steps submitters to find an appropriate alternative testing source.

DSHS laboratory staff is aware that certain infectious diseases require immediate action to investigate and prevent further disease spread. If the testing for these diseases is moved to a private sector laboratory, DSHS will need to put systems in place to ensure the timely provision of crucial result reports to epidemiological staff for follow-up.

## IX. MAJOR ISSUES – CONTINUED

### A. Brief Description of Issue

**Issue 2: What is the best use of limited State Hospital resources?**

### B. Background/Discussion

DSHS State Hospitals provide acute and sub-acute inpatient mental health treatment to psychiatric patients statewide, some of which are contracted through hospitals in the private sector. Due to the great need for services, provision of inpatient hospitalization requires using both types of entities. Currently, full resources are not available to meet all the needs of the aging hospitals and the populations that they serve.

The State Hospital system provides care to 254 counties, some of which have few inpatient options. DSHS provides care for adults, forensic patients, geriatric patients, patients with cognitive and behavioral conditions, patients with multiple disabilities (hearing impaired, visually impaired), and children/adolescents. Clinical specialties provide assessment, evaluation, and treatment, including psychiatry, nursing, social work, psychology, education/rehabilitation services, nutrition, and spiritual care. Medical and dental clinics, x-ray and laboratory services, and other consultative services provide additional clinical support. Services are paid through General Revenue funds, private payment, private third party insurance, and Medicare and Medicaid programs.

Facilities located in Austin, Big Spring, Kerrville, Vernon/Wichita Falls, El Paso, Rusk, Terrell, San Antonio, and Harlingen provide inpatient care. Another facility in the State Hospital system, Texas Center for Infectious Diseases (TCID) in San Antonio, provides specialized care that is not found elsewhere in Texas and is rare in the entire country. TCID treats Hansen's disease and TB, including multi-drug resistant TB. Finally, Waco Center for Youth provides inpatient residential treatment for children ages 12-18.

### C. Possible Solutions and Impact

One solution includes the ongoing assessment of the needs of Texas communities and the development of a response that alters the availability of civil and forensic psychiatric services specific to the various demographic and clinical populations requiring those services. This concept is currently being operationalized and integrated in a 10-year plan under development for both DSHS State Hospitals and Department of Aging and Disability Services State Supported Living Centers, as directed by the 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, DSHS, Rider 83). Through creation of a long-term plan for the

provision of psychiatric services, the State can better determine future capacity needs, address population growth, contain costs, and accommodate changes in healthcare financing.

Another potential solution might include the continued expansion of contracting privatized beds, as described in Issue 1.

## IX. MAJOR ISSUES – CONTINUED

### A. Brief Description of Issue

**Issue 3: Should DSHS have flexibility in its ability to oversee certain regulated entities?**

### B. Background/Discussion

DSHS has regulatory authority for many types of healthcare and consumer product delivery entities (e.g., hospitals, drug manufacturers, and distributors). However, statute's, sometimes narrow definitions, may limit companies seeking to do business in Texas. The provisions may impact entities seeking to provide additional options for patients/consumers. For healthcare facilities, the impetus is often to be able to bill for services as a facility instead of billing as an individual provider (e.g., physician, nurse practitioner). Examples include the following.

- Some entities decided a few years ago that they wanted to provide emergency care at the level of a hospital emergency department, but they did not want to provide inpatient care. There was no regulatory schema for this new type of healthcare facility. The change took two legislative sessions, but the Legislature ultimately passed a bill creating a new license type, free-standing emergency centers.
- Recently, DSHS has been asked to consider licensing a jail and a bulimia/anorexia residential clinic as hospitals.
- A number of entities that would probably be more appropriately licensed as ambulatory surgery centers (ASCs) have become licensed as hospitals because the type of surgeries they do might require their patients to stay longer than the 24-hour federal limit on ASCs.
- An example outside the healthcare facility strategy is compounding pharmacies that want to export products to other states. A number of compounding pharmacies that may meet the compounding requirements under the state pharmacy statute also seek to be licensed by DSHS as a drug manufacturer or distributor because other states require the Texas license for reciprocity. However, these compounding pharmacies may not meet the standards required for manufacturer or distributor licenses.

Universally, when an entity seeks a license that does not clearly align with its business model, DSHS is asked to waive many of the requirements, which are considered minimum standards. Some of these requirements are key elements for patient or consumer protection, such as emergency services, life safety code requirements, or good manufacturing principles. Some are federal requirements that cannot be waived. Historically, entities that meet the requirements are opposed to new entities receiving the same license without meeting the same requirements. For example, hospitals meeting the requirement for an on-site physician to provide emergency services oppose the efforts of some entities to change the requirements for physician coverage.

In addition to flexibility relating to entities that do not fit the current law and regulations, DSHS has likewise identified a need for flexibility in its ability to investigate entities that are not compliant with regulations. For instance, there is a growing trend in healthcare and consumer product delivery industries to hide control and ownership of companies through various privately held and specialized corporations and/or private partnerships. These complex organizations are often formed to shield assets and individuals from litigation and/or sanctions or to circumvent existing regulatory activities, challenging the success and ability of the agency to properly investigate and enforce regulatory requirements. In some cases, the owner of a problem business is out-of-state and fundamentally out of reach of Texas administrative laws.

A recent example is a physician who leased or purchased a number of rural hospitals, setting each up as a separate corporation that he wholly owned. Problems began to emerge in these facilities but the common ownership was not readily apparent. Two other examples include the following.

- An investigation led to a proposed enforcement action; however, the company investigated was owned by a second holding corporation and the manager was listed as the contact person. Further background work was needed to determine that the actual owner of the second holding corporation lived in California and had legal issues involving allegations of Centers for Medicare & Medicaid (CMS) fraud.
- A minority stakeholder was listed as an organization's contact person, while the principle stakeholder was a second corporation set up to shield the true company owners from having required criminal background checks done prior to the State issuing a license.

## C. Possible Solutions and Impact

The issues described above are complex and are present across all of the major DSHS regulatory programs. Greater flexibility within statutes would allow DSHS to create new license "types" through the rulemaking process. However, this approach may be met with concern by the entities that meet the current requirements and would prefer that there not be such flexibility. In addition, federal entities such as CMS and the Food and Drug Administration have voiced concerns about the rapidly growing numbers of certain types of entities in Texas, which in many cases exceeds population growth.

Mandating greater ownership disclosure requirements could improve DSHS' ability to take regulatory action and to track individuals who may try to reenter a field in which they have already been disciplined or are a potential threat to consumers or patients. Additionally, as a part of the application process for business entities, the applicants could be required to list all persons having a five percent or greater share in the company. Other possible options to address this issue may exist in other states.

## IX. MAJOR ISSUES – CONTINUED

### A. Brief Description of Issue

**Issue 4: Do certain functions currently housed at DSHS detract from the Department's public health focus?**

### B. Background/Discussion

DSHS has identified a number of functions that are statutorily assigned to the agency, but which may not be directly related to the agency's public health mission. These include certain regulatory functions, chemical reporting functions, and animal welfare functions.

Some licensing and regulatory programs housed within the DSHS Division for Regulatory Services:

- have no direct relationship to public health;
- have only an indirect relationship to public health;
- are regulated locally as well as regulated by DSHS;
- have voluntary regulation; or
- are more closely related to law enforcement functions than public health functions.

The following regulatory programs are examples of programs that have one or more of those characteristics: tanning beds, tattoo and body piercing, certified food managers, dyslexia therapists and practitioners, massage therapists, opticians' registry, rendering, certificates of free sale, bedding, personal emergency response system providers, and code enforcement officers.

The Community Right-to-Know Program, also housed within the DSHS Division for Regulatory Services, administers state and federal requirements for facilities that hold hazardous substances or extremely hazardous substances. These facilities must annually report storage capacity to DSHS, local fire chiefs, and local emergency planning committees. The requirement applies to manufacturing facilities, non-manufacturing facilities, and public employers, including refineries, cities, and fertilizer plants. DSHS serves as an information repository for these reports and has no authority to oversee the amounts, locations, manner of storage, or types of chemicals stored at facilities. Nearly 68,000 facilities statewide submit annual reports. DSHS has inspection authority in the program, which is limited, discretionary, and related to failure to report. The intent of the statute is to encourage community awareness and emergency planning.

Through the years, DSHS has also been tasked in statute with many animal welfare duties. The statutes and associated rules are administered and implemented by the Zoonosis Control Branch (within the Division for Disease Control and Prevention Services) and Regional Zoonosis

Control Programs (within the Division for Regional and Local Health Services). The agency has generally been required to meet the mandates with existing personnel and fiscal resources. These mandates have included animal euthanasia training; animal control officer training; dog and cat sterilization; regulation of circuses, carnivals, and zoos; regulation of dangerous wild animals; and animal shelters. The mission of the Zoonosis Control Branch and the Regional Zoonosis Control Programs is to prevent the transmission of diseases from animals to humans through epidemiologic measures, intervention strategies, and educational efforts. DSHS addresses animal welfare mandates, using the same resources dedicated to the agency's public health responsibilities, which could impact the capacity of the agency to meet its public health mission.

## C. Possible Solutions and Impact

Consideration could be given as to whether the functions described above should continue to be performed by state government and, if so, whether they are appropriately placed within the State's public health agency. Any movement of these programs to other agencies would impact each program's stakeholders and interest groups, who may or may not be supportive, and could result in a transfer of funding and staff resources from DSHS to other agencies.

## IX. MAJOR ISSUES – CONTINUED

### A. Brief Description of Issue

**Issue 5: Do existing statutory caps on fees limit available funding?**

### B. Background/Discussion

Most programs within the DSHS Division for Regulatory Services are statutorily required to achieve cost recovery through fee revenue. The following 13 programs have statutory caps on their fees; all but hospital licensing and some asbestos licenses have fees at the statutory cap:

- asbestos removal licensure,
- abusable volatile chemical permit,
- bedding permit,
- bottled and vended water,
- emergency medical services,
- frozen desserts,
- hospital licensing,
- mammography systems certification,
- milk industry products permit,
- oyster sales certification,
- private psychiatric hospital and crisis stabilization units,
- special care facilities, and
- workplace (Tier II) chemical reporting.

Fee caps have sometimes challenged the agency's ability to ensure that the total cost of regulation is covered by fee revenue. Because most of the programs are at the cap, DSHS would not have the ability to adjust fees for these programs if costs increased. Currently, all but 2 of the 13 programs are generating fee revenues in amounts that exceed appropriations.

The *Operational Evaluation of the Division of Regulatory Services at DSHS*, as required by the 2012-13 General Appropriations Act, House Bill 1, 82nd Legislature, Regular Session, 2011 (Article II, DSHS, Rider 59), addressed the issue of fees assessed by regulatory programs. One of the report recommendations was that the Division for Regulatory Services develop a standardized decision-making process to evaluate new and existing fees across regulatory programs. The proposed redesign will require consideration of the statutory limits within which DSHS must operate.

### C. Possible Solutions and Impact

Consideration could be given as to whether the statutory fee caps should be abolished and the agency should be given authority to set fees in amounts reasonable and necessary to cover program costs. This would ensure that, if program costs increase, the agency would have a mechanism to cover any shortfalls.

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## X. OTHER CONTACTS

**A. Fill in the following chart with updated information on people with an interest in your agency, and be sure to include the most recent e-mail address.**

| **Department of State Health Services<br>Exhibit 14: Contacts** | | | |
|---|---|---|---|
| **INTEREST GROUPS**<br>(groups affected by agency actions or that represent others served by or affected by agency actions) | | | |
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Advanced Medical Technology Association/ Nancy Singer | 701 Pennsylvania Avenue, Northwest, Suite 800 Washington, D.C. 20004 | 202-783-8700 | info@advamed.org |
| Association of Professionals in Infection Control and Epidemiology/ Marla Dalton | 1275 K Street Northwest, Suite 1000 Washington, DC 20005 | 202-789-1890 | apicinfo@apic.org<br>mdalton@apic.org |
| Association of Substance Abuse Programs/ Cynthia Humphrey | 169 Catalina Court Kerrville, TX 78028 | 830-792-4541 | chumphrey@asaptexas.org |
| Association of Texas Medical Equipment Dealers/ John Shepperd | P.O. Box 684181 Austin, TX 78768 | 512-482-0270 | info@aotmed.org |
| Baptist Health System | 1 Lexington Medical Building<br>215 East Quincy, Suite 200<br>San Antonio, TX 78215 | 210-297-1000 | https://www.baptisthealthsystem.com/contact.aspx |
| Black Christians Against Substance Abuse/ Alonzo Bradley | 2951 East 14th Street Austin, TX 78702 | 512-476-6611 | alonzo.bradley@co.travis.tx.us |

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| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Blue Cross Blue Shield of Texas/ Dr. Jerald Zarin | 1001 East Lookout Drive<br>Richardson, TX 75082 | 972-766-6900 | jerald_zarin@bcbstx.com |
| Caremark Therapeutic Services/ Becky Schroeder | 1127 Bryn Mawr Avenue<br>Redlands, CA 92374 | 909-796-7171 | becky.schroeder@caremark.com |
| Central Texas Healthy Mothers, Healthy Babies Coalition/ Janet Rourke | 6724 Oasis Drive<br>Austin, TX 78749 | 512-301-8682 | hmhb@hmhbcentx.org |
| Children's Environmental Health Institute/ Janie D. Fields | P.O. Box 50342<br>Austin, TX 78763-0342 | 512-657-7405 | janie.fields@cehi.org |
| Children's Hospital Association of Texas | 823 Congress Avenue, Suite 1500<br>Austin, TX 78701 | 512-320-0910 | info@texaschildrens.org |
| Choice Source Therapeutics/ John Mitchell | 2100 North Highway 360,<br>Suite 1700<br>Grand Prairie, TX 77505 | 800-992-3490 | grand_prairie@choicesource.com |
| Citizens for Environmental Justice/ Suzie Canales | 5757 South Staples, #2506<br>Corpus Christi, TX 78413 | 361-334-6764 | scanales@grandecom.net<br>cfej2000@yahoo.com |
| Coalition for Nurses in Advanced Practice Jennifer Fontana | P.O. Box 86<br>Cedar Park, TX 78630 | 512-694-8346 | jennifer@cnaptexas.org |

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| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Coastal Oyster Leaseholders Association, Inc./ Guy Jackson | P.O. Drawer CC<br>Anahuac, TX 77514-1729 | 800-259-0852 | guyjax@ih2000.net |
| Code Enforcement Association of Texas/<br>Melissa Govea | P.O. Box 28476<br>San Antonio, TX 78228 | 972-304-3522 | mgovea@coppelltx.gov |
| Conference of Urban Counties/<br>Don Lee | 500 West 13th Street<br>Austin, TX 78701 | 512-476-6174 | donlee@cuc.org<br>michael@cuc.org |
| Consumers' Union/<br>Lisa McGiffert | Southwest Regional Office<br>506 West 14th Street<br>Austin, TX 78701 | 512-477-4431 | lmcgiffert@consumer.org |
| Council of Families for Children/<br>Deborah Rose | 213 Camilla Lane<br>Garland, TX 75040 | 972-494-3232 | info@counciloffamilies.org |
| County and District Clerks Association of Texas/<br>Sheri Woodfin | Tom Green District Clerk<br>112 West Beauregard<br>San Angelo, TX 76903 | 325-659-6579 | infor@cdcatexas.org<br>sheri.woodfin@co.tom-green.tx.us |
| Dairy Farmers of America/<br>David Jones | 3500 William D. Tate Avenue<br>Grapevine, TX 76051-7102 | 817-410-4500 | djones@dfamilk.com |
| Dairy Products Institute/<br>Mark Compere | P.O. Box 4924<br>Horseshoe Bay, TX 78657 | 830-596-7060 | dpioftexas@aol.com |
| Disability Policy Consortium | 1016 La Posada,<br>Suite 145<br>Austin, TX 78752 | 512-371-1783 | info@dpctexas.org |

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| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Disability Rights Texas/<br>Mary Faithful | 2222 West Braker Lane<br>Austin, Texas 78758 | 512-454-4816 | info@disabilityrightstx.org |
| EMS Association of Texas/<br>Ron Haussucker | 1100 East Horton<br>Brenham, TX 11833 | 979-277-6267 | mail@emsatoftx.org |
| End Stage Renal Disease Network of Texas #14/<br>Glenda Harbert | 4040 McEwen Road,<br>Suite 350<br>Dallas, TX 75244 | 972-503-3215 | gharbert@nw14.esrd.net |
| Epilepsy Foundation of Central and South Texas/<br>Sindi Rosales | 10615 Perrin Beitel Road,<br>Suite 602<br>San Antonio, TX 78217-3142 | 210-653-5353 | sindi@efcst.org |
| Epilepsy Foundation of Texas/<br>Donna Stahlhut | 2630 Fountain View Drive,<br>Suite 210<br>Houston, TX 77057 | 713-789-6295 | dstahlhut@eftx.org<br>info@eftx.org |
| Epilepsy Outreach Program - Parkland Memorial Hospital/<br>Roseann Murphy | 5201 Harry Hines Boulevard<br>Dallas, TX 75235 | 214-590-8877 | ramurp@parknet.pmh.org |
| Health Physics Society, South Texas Chapter/<br>Scott M. Nichelson | 3630 Stanley Road<br>Suite 307<br>Fort Sam Houston, TX 78234 | 210-221-8833 | scott.m.nichelson.civ@mail.mil |
| Hogg Foundation for Mental Health/<br>Octavio Martinez | 3001 Lake Austin Boulevard<br>Austin, TX 78703-4200 | 512-471-5041 | hogg-info@austin.utexas.edu |

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| Hospital Corporation of America - North Texas Division/ Mike Roussos | 6565 North Macarthur Boulevard<br>Irving, TX 75039 | 972-401-8776 | http://hcanorthtexas.com/about/contact-us.dot |
| Justices of the Peace and Constables Association of Texas/ Martin Castillo | 1200 West Pearl Street<br>Granbury, TX 76048 | 817-579-3290 | mcastillo@co.hood.tx.us |
| LifeRamp Family Financial, Advocacy and Public Relations/ Susan Boucher | 1600 Corporate Court, Suite 140<br>Dallas, TX 75038 | 469-524-7032 | sboucher@liferamp.com |
| MADD Texas | 3910 IH 35, Suite 225<br>Austin, TX 78704 | 512-445-4976 | tx.state@madd.org |
| March of Dimes, Texas Division/ Shannon Lucas | 11044 Research Boulevard<br>Austin, TX 78759 | 512-477-3221 | slucas@marchofdimes.com |
| Medical Device Manufacturers Association/ Mark Leahey | 1350 H Street Northwest,<br>Suite 400 West<br>Washington, D.C. 20005 | 202-354-7171 | msmainfo@medicaldevices.org |
| Medical Equipment Suppliers/ Association | 509 South Chickasaw Trail, Suite 178<br>Orlando, FL 32825 | 888-414-6372 | mesa@mesanet.org |
| Mental Health America of Texas | 1210 San Antonio Street<br>Austin, TX 78701 | 512-454-3706 | mhainfo@mhatexas.org |

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| Multiple Sclerosis Society of Texas | 8111 North Stadium Drive, Suite 100<br>Houston , TX 77054 | 713-526-8967 | txh@nmss.org |
| National Alliance on Mental Illness – Texas/<br>Kent Reynolds | Fountain Park Plaza III<br>2800 South IH 35, Suite 140<br>Austin, TX 78704 | 512-693-2000<br>800-633-3760 | executivedirector@namitexas.org |
| Opticians Association of Texas | 3636 Bee Cave Road, Suite 102<br>Austin, TX 78746 | | coatpresident@yahoo.com |
| Parents Requesting Open Vaccine Education/<br>Dawn Richardson | P.O. Box 91566<br>Austin, TX 78709-1566 | 512-288-3999 | prove@vaccineinfo.net<br>contactus1@vaccineinfo.net |
| Paso Del Norte Health Foundation/<br>Enrique Mata | 221 North Kansas, Suite 1900<br>El Paso, TX 79901 | 915-544-7636 | emata@pdnhf.org<br>health@pdnhf.org |
| Radiological Physics Associates | 7711 Louis Pasteur, Suite 609<br>San Antonio, TX 78229 | 210-616-0700 | physics@rpa-sa.com |
| Safe Communities/<br>Irene Rodriquez | Texas Transportation Institute<br>3135 TAMU<br>College Station, TX 77843-3135 | 979-458-0701 | I-rodriguez@ttimail.tamu.edu |
| Safe Kids Austin/<br>Stephanie Hebert | 4900 Mueller Boulevard<br>Austin, TX 78723 | 512-324-0000 | sdhebert@seton.org |
| South Texas Cancer Center/<br>Sylvia Arenas | 2150 North Expressway, #83<br>Brownsville, TX 78521 | 956-548-0810 | http://cancercaresouthtexas.com/about/contact/ |

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| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Southwest Prevention Center, Center for Substance Abuse Prevention/ Regional Expert Team | 1639 Cross Center Drive,<br>Room 254<br>Norman, OK 73072 | 405-325-6110 | swpc@ou.edu |
| Southwest Regional Cancer Center/ David George | 901 West 38th Street<br>Suite 300<br>Austin, TX 78705-1125 | 512-421-4100 | dgeorge@swrcc.com |
| Southwestern Ice Association/ Laron Hike | 823 Congress Avenue,<br>Suite 230<br>Austin, TX 78701 | 512-479-0425 | sbulak@eami.com |
| Spina Bifida Association – Texas/ Nora A. Oyler | 1550 Northeast Loop 410<br>Suite 224<br>San Antonio, TX 78209 | 210-826-7289 | noyler@sbtx.org |
| Susan G. Komen Breast Cancer/ Foundation | 5005 LBJ Freeway,<br>Suite 250<br>Dallas, TX 75244 | 877-465-6636 | info@komenaustin.org |
| Teaching Hospitals of Texas/ Maureen Milligan | 1005 Congress,<br>Suite 830<br>Austin, TX 78701 | 512-476-1497 | http://thotonline.org/index.php?module=contact |
| Texans Standing Tall/ Nicole Holt | 2211 South IH 35,<br>Suite 201<br>Austin, TX 78741 | 512-442-7501 | nholt@texansstandingtall.org |
| Texas Academy of Audiology/ Jackie Clark | P.O. Box 93331<br>Lubbock, TX 79493-3331 | 214-905-3031 | http://www.texasaudiology.org/contact.asp?recipient=President&RolesID=1 |
| Texas Academy of Family Physicians | 12012 Technology Boulevard, Suite 200<br>Austin, TX 78727 | 512-329-8666 | tafp@tafp.org |

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| Texas Academy of Pediatric Dentistry/ Monica Fairchild | 5414 27th Street<br>Lubbock, TX 79407 | | email@tapd.org |
| Texas Academy of Physicians Assistants/ Lisa Jackson | 401 West 15th Street<br>Austin, TX 78701 | 512-370-1537<br>800-280-7655 | lisa.jackson@texmed.org |
| Texas AIDS Network/ Carolyn Parker | 5611 Oak Boulevard<br>Austin, TX 78735-8709 | 512-892-0188 | |
| Texas Ambulance Association/ Ron Beaupre | P.O. Box 700635<br>Dallas, TX 75370-0635 | 972-417-2878 | txambinfo@txamb.com |
| Texas Ambulatory Surgery Center Society/ Bobby Hillert | 401 West 15th Street, Suite 695<br>Austin, TX 78701 | 512-469-7900 | bhillert@texasascsociety.org |
| Texas American Indian Information and Resource Network/ Chebon Tiger | 1701 South Mays, Suite J,<br>Box 197<br>Round Rock, TX 78664 | 512-300-7992 | ctiger@austin.rr.com |
| Texas Animal Control Association/ Cathy Clark | P.O. Box 150637<br>Lufkin, TX 75915-0637 | 800-324-8503 | tacaexsc@consolidated.net |
| Texas Association Against Sexual Assault/ Annette Burrhus-Clay | 6200 La Calma Drive, #110<br>Austin, TX 78752-3800 | 512-474-7190 x 8165 | aclay@taasa.org |

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| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Association for Education of Young Children/ Lashonda Brown | P.O. Box 4997<br>Austin, TX 78765-4997 | 800-341-2392 | lbrown@texasaeyc.org<br>taeyc@texasaeyc.org |
| Texas Association for Marriage and Family Therapists/ Jessica Balladares-Bennett | P.O. Box 49009<br>Austin, TX 78765-9009 | 512-263-4048<br>801-270-4320 | Jbennett@tamft.org<br>admin@tamft.org |
| Texas Association of Addiction Professionals/ Tricia Sapp | 1005 Congress Avenue, Suite 460<br>Austin, TX 78701 | 512-708-0629<br>817-308-7896 | admin@taap.org |
| Texas Association of Business/ Ron Luke | 1209 Nueces Street<br>Austin, TX 78701-1209 | 512-477-6721 | rluke@rpcconsulting.com |
| Texas Association of Community Health Centers/ Jose Camacho | 5900 Southwest Parkway, Building 3<br>Austin, TX 78735 | 512-329-5959 | Jcamacho@tachc.org |
| Texas Association of Counties/ Sam Seale | 1) 1210 San Antonio Street<br>Austin, TX 78701<br>2) P.O. Box 2131<br>Austin, TX 78768-2131 | 512-478-8753 | sams@county.org |
| Texas Association of Dairymen/ John Cowan | 3500 William D. Tate Avenue<br>Grapevine, TX 76051-7102 | 817-410-4538 | jcowan@dfamilk.com<br>tadinfo@milk4texas.org |
| Texas Association of Drug Court Professionals/ Judge Lila Mays | 133 North Industrial<br>Dallas, TX 75207 | 214-653-5877 | ccorder@shsu.edu |

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| Texas Association of Health Plans/ Jared Wolfe | 1001 Congress Avenue, Suite 300<br>Austin, TX 78701 | 512-476-2091 | jwolfe@tahp.org |
| Texas Association of Local Health Officials/ Jennifer Smith | 2600 McHale Court, #100<br>Austin, TX 78758 | 512-814-2546 | jennifer.smith@talho.org |
| Texas Association of Local WIC/ Directors<br>Karen Gibson | P.O. Box 49276<br>Austin, TX 78765 | 713-728-8590 | info@talwd.org |
| Texas Association of Massage Therapists/ Diane Esparza | 2702 Joshua Trail<br>Mansfield, TX 76063 | 888-778-9851 | info@texasmassagetherapists.com<br>dianeesp@earthlink.net |
| Texas Association of Obstetricians and Gynecologists/ Karen O'Briant | 141 Idlewild Creek Road<br>Sweetwater, TX 79556 | 325-235-1959 | taog@hotmail.com |
| Texas Association of Regional Councils/ Penny Redington | 701 Brazos, Suite 780<br>Austin, TX 78701 | 512-478-4715 | predington@txregionalcouncil.org<br>tarc@txregionalcouncil.org |
| Texas Association of Rural Health Clinics/ Ramsey Longbotham | P.O. Box 14547<br>Austin, TX 78761 | 512-873-0045 | ramsey@tarhc.org<br>ramseyl@tisd.net |
| Texas Association of Social Workers/ Vicki Hansen | 810 West 11th Street<br>Austin, TX 78701 | 512-474-1454 | vhansen@naswtx.org<br>naswtex@naswtx.org |

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| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Association of Trauma Regional Advisory Councils/ Richard Lockwood | 2605 Starr Drive<br>Waco, TX 76710 | 254-202-8571 | rlockwood@hillcrestreet.net |
| Texas Bottled Water Association/ Susan Gibson | 14101 Highway 290 West, Building 900-B<br>Austin, TX 78737 | 512-894-4106 | susangibson@austin.rr.com |
| Texans Care for Children/<br>Eileen Garcia | 811 Trinity, Suite A<br>Austin, Texas, 78701 | 512-473-2274 | egarcia@texanscareforchildren.org |
| Texas CASA<br>Megan Ferlund/<br>Myriah Mikulencak | 1501 West Anderson Lane,<br>Suite B-2<br>Austin, TX 78757 | 512-473-2627 | txcasa@texascasa.org<br>mmikulencak@texascasa.org |
| Texas Certification Board of Addiction Professionals/<br>Leslie Adkins | 1005 Congress, Suite 460<br>Austin, TX 78701 | 512-708-0629 | tcbap@tcbap.org<br>:tladkins@thetexascapitol.com |
| Texas Chemical Council/<br>Hector Rivero | 1402 Nueces Street<br>Austin, TX 78701-1586 | 512-646-6400 | rivero@txchemcouncil.org |
| Texas College of Emergency Physicians/<br>Jerry Gray | 2525 Wallington Drive, Building 13A<br>Austin, TX 78746 | 512-306-0605 | tcep@aol.com |
| Texas Conference of Urban Counties/<br>Windy Johnson | 500 West 13th Street<br>Austin, TX 78701 | 512-476-6174 | Windy@cuc.org |
| Texas Council of Community MHMR Centers/<br>Danette Castle | Westpark Building 3, Suite 240<br>8140 North Mopac Expressway<br>Austin, TX 78759 | 512-794-9268 | dcastle@txcouncil.com<br>office@txcouncil.com |

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| Texas Council on Family Violence<br>Dyanne Purcell/ | P.O. Box 161810<br>Austin, TX 78716 | 512-794-1133 | dpurcell@tcfv.org |
| Texas Counseling Association<br>Jan Friese | 1204 San Antonio, Suite 201<br>Austin, Texas 78701 | 512-472-3403 | jan@txca.org |
| Texas Dental Association | 1946 South IH 35, Suite 400<br>Austin, TX 78704 | 512-443-3675 | jaida@tda.org |
| Texas Dental Association Smiles Foundation/<br>Judith Gonzalez | 1946 South IH 35, Suite 400<br>Austin, TX 78704 | 512-448-2441 | judith@tda.org |
| Texas Dermatological Society/<br>Laura Madole | 401 West 15th Street<br>Austin, TX 78701 | 512-370-1502 | laura.madole@texmed.org |
| Texas Dietetic Association/<br>Karen Beathard | 4230 LBJ Freeway, Suite 414<br>Dallas, TX 75244 | 972-755-2530 | President@eatrighttexas.org |
| Texas Nurses Association/<br>Ellarene Sanders | 8501 N. MoPac Expy., Suite 400<br>Austin, TX 78759 | 512-452-0645 | esanders@texasnurses.org;<br>tna@texasnurses.org |
| Texas EMS Trauma and Acute Care Foundation/<br>Jorie Klein,<br>Dinah Welsh | 3400 Enfield Road<br>Austin, TX 78703 | 512-524-2892 | info@tetaf.org<br>dwelsh@tetaf.org |
| Texas Environmental Health Association/<br>Betty Richardson | P.O. Box 860099<br>Plano, TX 75086-0099 | 972-461-9644 | brichardson@gchd.org |

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| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Federation of Animal Care Societies/ Patt Nordyke | 4702 Pinehurst Drive South<br>Austin, TX 78747 | 512-826-8605 | pnordyke@austin.rr.com |
| Texas Fire Chiefs Association/ Betty Wilkes | P.O. Box 66700<br>Austin, TX 78766 | 512-454-6350 | bwilkes@texasfirechiefs.org |
| Texas Food Processors Association/ Glendy Valdez | P.O. Box 341<br>College Station, TX 77841-0341 | 979-846-3285 | gvaldez@valdezspice.com<br>legislative@tfpa.org |
| Texas Funeral Directors Association/ Ann Singer | 1513 South IH 35<br>Austin, TX 78741 | 800-460-8332 | ann@tfda.com |
| Texas Grocery and Convenience Association/ Rick Johnson | 7719 Wood Hollow Drive, Suite 150<br>Austin, TX 78731 | 512-926-9285 | rick@txgca.org |
| Texas Health Care Association/ Dorothy Crawford | P.O. Box 4554<br>Austin, TX 78765 | 512-458-1257<br>800-380-2500 | dcrawford@txhca.org<br>thca@txhca.org |
| Texas Healthy Start Alliance/ Jerry Roberson | 4917 Harry Hines Boulevard<br>Dallas, TX 75235 | 817-822-4954 | mr.roberson@comcast.net |
| Texas Hospital Association/ Elizabeth Sjoberg | P.O. Box 679010<br>Austin, TX 78767-9010 | 512-465-1000 | esjoberg@tha.org<br>info@tha.org |
| Texas Humane Legislative Network | P. O. Box 685283<br>Austin, TX 78768-5283 | 888-548-6263 | cile@thln.org<br>rick@thln.org |

| Department of State Health Services<br>Exhibit 14: Contacts | | | |
|---|---|---|---|
| **INTEREST GROUPS**<br>(groups affected by agency actions or that represent others served by or affected by agency actions) | | | |
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Immunization Partnership/ Anna C. Dragsbaek | 3015 Richmond Avenue, Suite 270 Houston, TX 77098 | 281-400-3689 | acdragsbaek@immunizeusa.org |
| Texas Indigent Health Care Association/ Rita Kelley | 309 Priest Drive Killeen, TX 76541 | 254-519-1229 | Rita.Kelley@co.bell.tx.us |
| Texas Justice Court Center/ Roger Rountree | 701 Brazos Street, Suite 710 Austin, TX 78701 | 512-347-9927 | rr15@txstate.edu |
| Texas Licensed Child Care Association/ Tere Holmes | 5708 Hero Drive Austin, TX 78735 | 512-788-1235 | tlcca@gmail.com |
| Texas Medical Association | 401 West 15th Street Austin, TX 78701-1680 | 512-370-1300 | darren.whitehurst@texmed.org |
| Texas Medical Directors Association/ Kent Davis | 5430 Beeman Avenue Dallas, TX 75223 | 410-992-3136 | tmdawebsite@gmail.com |
| TMF Health Quality Institute/ Tom Manley | Bridgepoint I, Suite 300 5918 West Courtyard Drive Austin, TX 78730-5036 | 512-329-6610 | tmanley@tmf.org |
| Texas Municipal League/ Karla Vining, Lauren Crawford | 1821 Rutherford Lane, Suite 400 Austin, TX 78754 | 512-231-7400 | kvining@tml.org<br>lcrawford@tml.org<br>members@tml.org |
| Texas Nurses Association/ Ellarene Sanders | 8501 North MoPac Suite 400 Austin, TX 78759 | 512-452-0645 | esanders@texasnurses.org; tna@texasnurses.org |

| Department of State Health Services<br>Exhibit 14: Contacts | | | |
|---|---|---|---|
| **INTEREST GROUPS**<br>(groups affected by agency actions or that represent others served by or affected by agency actions) | | | |
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Oncology, P.A. | 12221 Merit Drive, Suite 500<br>Dallas, TX 75251 | 888-864-4226 | texasoncology@usoncology.com |
| Texas Onsite Wastewater Association/<br>Tim Taylor | 3205 North University Drive, Suite D<br>P.M.D. 411<br>Nacogdoches, TX 75965 | 888-398-7188 | tntaylor1@msn.com |
| Texas Optometric Association | 1104 West Avenue<br>Austin, TX 78701 | 512-707-2020 | toa@txeyedoctors.com |
| Texas Organization of Rural and Community Hospitals/<br>David Pearson | P.O. Box 203878<br>Austin, TX 78720 | 512-873-0045 | torch@torchnet.org |
| Texas Orthopedic Association/<br>Donna Parker | 401 West 15th Street, Suite 820<br>Austin, TX 78701 | 512-370-1505 | donna@toafoundation.org<br>info@toafoundation.org |
| Texas Osteopathic Medical Association/<br>Sam Tessan | 1415 Lavaca Street<br>Austin, TX 78701-1634 | 512-708-8662 | toma@txosteo.org<br>sam@txosteo.org |
| Texas Parent Teacher Association/<br>Karen Slay | 7600 Chevy Chase Drive Building Two, Suite 300<br>Austin, TX 78752 | 512-476-6769 | txpta@txpta.org<br>president@txpta.org |
| Texas Pediatric Society/<br>Mary Greene-Noble | 401 West 15th Street, Suite 682<br>Austin, TX 78701 | 512-370-1506 | http://txpeds.org/contact/executive-director |
| Texas Food and Fuel Association/<br>Doug DuBois | 401 West 15th Street, Suite 510<br>Austin, TX 78701 | 512-617-4305 | dedubois@tpca.org |

| Department of State Health Services<br>Exhibit 14: Contacts | | | |
|---|---|---|---|
| **INTEREST GROUPS**<br>(groups affected by agency actions or that represent others served by or affected by agency actions) | | | |
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Pharmacy Association/ Kim Roberson | 12007 Research Boulevard, Suite 201 Austin, TX 78759 | 800-505-5463 512-836-8350 | Kroberson@texaspharmacy.org |
| Texas Podriatric Medical Association/ Mark J. Hanna | 918 Congress Avenue, Suite 200 Austin, TX 78701 | 512-494-1123 | staff@txpma.org mhanna@markjhanna.com |
| Texas Public Health Association/ Terri Pali | P.O. Box 201540 Austin, TX 78720-1540 | 512-336-2520 | txpha@aol.com |
| Texas Public Interest Research Group | 815 Brazos, Suite 600 Austin, TX 78701 | 512-479-7287 | info@txpirg.org |
| Texas Renal Coalition/ Dale Matthews | Austin, TX | 512- 441-3444 | info@texasrenalcoalition.org |
| Texas Restaurant Association/ Robert Westbrook | 1400 Lavaca Austin, TX 78701 | 512-457-4100 | bobwestbrook@suddenlink.net |
| Texas Retailers Association/ Joe Williams | 504 West 12th Street, Austin, TX 78701 | 512-472-8261 | txretailers@txretailers.org |
| Texas School Nurses Organization/ Margaret Ryan | 819 West Arapaho Road, Suite 24-B, #345 Richardson, TX 75080 | | m151ryan@gmail.com |
| Texas Society for Respiratory Care | P.O. Box 515459 Dallas, TX 75251 | 972-495-9200 | tsrc@texoma.net |
| Texas Society for Clinical Social Workers/ Jennifer Hill | | | jhseguin@aol.com |

| Department of State Health Services<br>Exhibit 14: Contacts | | | |
|---|---|---|---|
| **INTEREST GROUPS**<br>(groups affected by agency actions or that represent others served by or affected by agency actions) | | | |
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Society of Infection Control Practitioners/ Jamie Kraft | P.O. Box 341357<br>Austin, TX 78734 | 512-263-2480 | Jk_tsicp@hotmail.com |
| Texas Society of Pathologists/ Jill Sutton | 401 West 15th Street<br>Austin, TX 78701 | 512-370-1510 | Jill.sutton@texmed.org |
| Texas Society of Psychiatric Physicians | 401 West 15th Street, Suite 675<br>Austin, TX 78701 | 512-478-0605 | TxPsychiatry@aol.com |
| Texas Speech-Language-Hearing Association | 2025 M Street NW, Suite 800<br>Washington, DC 20036 | 855-330-8742 | tsha@courtesyassoc.com |
| Texas State Association of Fire Fighters/ Mike Higgins | 627 Radam Lane<br>Austin, TX 78745 | 512-326-5050 | mhiggins@tstaff.org |
| Texas State Athletic Trainers' Association/ Spanky Stephens | 1676 Coushatte Road<br>Bellville, TX 77418 | 866-886-1688 | trainerex@earthlink.net |
| Texas Suicide Prevention Society/ Mary Ellen Nudd | 1210 San Antonio Street<br>Austin, TX 78701 | 512-454-3706 | menudd@mhatexas.org |
| Texas Trauma Coordinators Forum/ Scott Christopher | P.O. Box 177<br>Wichita Falls, TX 76307 | 936-569-4119 | christos@nacmem.org |

| Department of State Health Services<br>Exhibit 14: Contacts | | | |
|---|---|---|---|
| **INTEREST GROUPS**<br>(groups affected by agency actions or that represent others served by or affected by agency actions) | | | |
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Tumor Registrars Association/ Gay Jordan | 1) Oncology Network Consultants<br>4101 James Casey Boulevard, Suite 100<br>Austin, TX;<br>2) c/o Nita Raidy<br>205 Prairie View<br>Red Oak, TX 75154 | 512-912-2771<br>817-264-4591 | president@txtra.org |
| Texas Veterinary Medical Association/ Chris Copeland | 8104 Exchange Drive<br>Austin, TX 78754 | 512-452-4224 | ccopeland@tvma.org |
| Women's Health and Family Planning Association of Texas/ Fran Hagerty | P.O. Box 3868<br>Austin, TX 78764 | 512-448-4857 | info@whftp.org |
| Workers Assistance Program/ Terry Cowan | 4115 Freidrich Lane, Suite 100<br>Austin, TX 78744 | 512-343-9595<br>877-287-1533 | trcowan@workersassistance.com<br>cts@workersassistance.com |

| INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS<br>(that serve as an information clearinghouse or regularly interact with your agency) | | | |
|---|---|---|---|
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| **REGIONAL AND STATE LEVEL** | | | |
| Baylor University Medical Center at Dallas, Health Information Management Department | 3500 Gaston Avenue<br>Dallas, TX 75246 | 214-818-6342 | |
| Central Texas Poison Center<br>Jennifer Watson | Scott & White Hospital<br>2401 South 31st Street<br>Temple, TX 76508 | 254-724-7409 | jawatson@swmail.sw.org |
| Children's Wellness Center/<br>Linda Murphy | 5301 H Ross Road<br>Del Valle, TX 78617 | 512-386-3335 | lmurphy@mail.nur.utexas.edu |
| East Texas Area Health Education Center/<br>Steve Shelton | 301 University Boulevard<br>Galveston, TX 77555-1056 | 409-772-7884 | steve.shelton@utmb.edu |
| Greater Houston Area Chapter of the ALS Association | P.O. Box 271561<br>Houston, TX 77277-1561 | 713-942-2572 | linda.richardson@alsa-houston.org |
| Harris County Hospital District /<br>David Lopez | 2525 Holly Hall<br>Houston, TX 77054 | 713-566-6400 | David_lopez@hchd.tmc.edu |
| Interagency Council for Genetic Services/<br>Debra Freedenberg | 1100 West 49th Street<br>Austin, TX 78756 | 512-458-7111 x3101 | debra.freedenberg@dshs.state.tx.us |
| National Kidney Foundation/<br>Naomi Dingle | 5429 LBJ Freeway, Suite 250<br>Dallas, TX 75240 | 877-543-6397 | texasinfo@kidney.org |
| North Texas Chapter of the ALS Association/<br>Doris Ricks-Lankford | 1231 Greenway Drive, Suite 270<br>Irving, TX 75038 | 972-714-0088 | d.ricks@alsanorthtexas.org |

| INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS<br>(that serve as an information clearinghouse or regularly interact with your agency) | | | |
|---|---|---|---|
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| North Texas Poison Center/<br>Jorie Klein | 5201 Harry Hines Boulevard<br>Dallas, TX 75235 | 214-590-8717 | Jorie.Klein@phhs.org |
| Rotary International – Austin University Chapter/<br>Clift Price, M.D. | 2108 Robert Dedman Drive<br>Austin, TX 78712 | 512-266-3622 | cprice59@austin.rr.com |
| South Texas Chapter of the ALS Association/<br>Stephen Morse | 8600 Wurzbach, Suite 700<br>San Antonio, TX 78229-3900 | 210-733-5204 | smorse@alsasotx.org |
| South Texas Poison Center/<br>Miguel Fernandez, M.D. | 7703 Floyd Curl Drive<br>San Antonio, TX 78284-7849 | 210-567-5762 | FernandezMC@uthscsa.edu<br>jimenezc@uthscsa.edu |
| Southeast Texas Poison Center/<br>Jon Thompson | 3.112 Trauma Center<br>301 University Boulevard<br>Galveston, TX 77555-1175 | 409-772-9142 | jdthomps@utmb.edu |
| Texas A&M University, Department of Biomedical Engineering | Department of Biomedical Engineering<br>337 Zachry Engineering Center, 3120 TAMU<br>College Station, TX 77843-3120 | 979-845-5532 | bmen@tamu.edu |
| Texas A&M School for Rural Public Health/<br>Kenneth R. McLeroy | University Drive and Adriance Lab Road<br>MS 1266<br>College Station, TX 77843-1266 | 979-845-2387 | kmcleroy@srph.tamhsc.edu |
| Texas A&M University Health Science Center/<br>Carol Ames | 301 Tarrow<br>College Station, TX 77840 | 979-458-7200 | ames@tamhsc.edu |

| INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS<br>(that serve as an information clearinghouse or regularly interact with your agency) | | | |
|---|---|---|---|
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Christian University, Institute of Behavioral Research | TCU Box 298740<br>Fort Worth, TX 76129 | 817-257-7226 | ibr@tcu.edu |
| Texas Health Institute/<br>Camille Miller | Reunion Park Building I<br>8501 North MoPac Expressway, Suite 300<br>Austin, TX 78759 | 512-279-3910 \| | cmiller@texashealthinstitute.org |
| Texas Military Forces/<br>Colonel Connie McNabb | P.O. Box 5218<br>Austin, TX 78763-5218 | 512-782-5022 | connie.mcnabb@us.army.mil |
| Texas Panhandle Poison Center/<br>Jeanie Jaramillo | 1501 South Coulter<br>Amarillo, TX 79106 | 806-354-1630 | jeanie.jaramillo@ttuhsc.edu |
| Texas Public Health Training Center/<br>Jeff Talbert | 3500 Camp Bowie Boulevard<br>Fort Worth, TX 76107 | 713-500-9399<br>713-500-9392 | tphtc@uth.tmc.edu |
| Texas State University, San Marcos, College of Health Professions/<br>Ruth Welborn | 601 University Drive, Room 201<br>San Marcos, TX 78666 | 512-245-3300 | rwelborn@txstate.edu |
| Texas Tech University Health Science Center/<br>Patti Patterson | 3601 4th Street<br>Lubbock, TX 79430 | 806-743-1000 | patti.patterson@ttuhsc.edu |
| University of North Texas Health Science Center - School of Public Health, Dept. of Health Management & Policy/<br>Ywanda Kimbrough | 3500 Camp Bowie Boulevard<br>Ft. Worth, TX 76107 | 817-735-2242 | ywandakimbrough@unthsc.edu |

| INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS<br>(that serve as an information clearinghouse or regularly interact with your agency) | | | |
|---|---|---|---|
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| University of Texas LBJ School of Public Affairs/<br>David C. Warner | P.O. Box Y<br>Austin, TX 78713 | 512-471-6277 | david.warner@mail.utexas.edu |
| University of Texas Health Science Center at Houston, School of Public Health/<br>Guy Parcel | P.O. Box 20186<br>Houston, TX 77025 | 713-500-9000 | guy.s.parcel@uth.tmc.edu<br>SPHInfo@uth.tmc.edu |
| University of Texas Health Science Center at San Antonio/<br>Juan M. Parra | 7703 Floyd Curl Drive<br>San Antonio, TX 78229 | 210-567-7000 | parraj@uthscsa.edu |
| University of Texas School of Public Health at Brownsville/<br>**Joseph McCormick** | UTSPH 80 Fort Brown<br>RAHC-N.200<br>Brownsville, TX 78520 | 956-882-5165 | joseph.b.mccormick@uth.tmc.edu |
| University of Texas Center for Social Work Research/<br>Carol Lewis | 1925 San Jacinto Boulevard,<br>Austin, TX 78712 | 512-471-9219 | carolmarie@mail.utexas.edu |
| University of Texas Southwestern Medical Center | 5323 Harry Hines Boulevard<br>Dallas, TX 52390 | 214-648-3111 | angelica.marin-hill@utsouthwestern.edu |
| University of Texas MD Anderson Cancer Center/<br>Lewis Foxhall | 1515 Holcombe Boulevard, Unit 1487<br>Houston, TX 77030 | 713-745-1161 | lfoxhall@mdanderson.org |
| University of Texas Medical Branch at Galveston/<br>Laura Rudkin | 1.128A Ewing Hall<br>Galveston, TX 77555 | 409-772-9132 | lrudkin@utmb.edu |

| INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS<br>(that serve as an information clearinghouse or regularly interact with your agency) | | | |
|---|---|---|---|
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| University of Texas Austin Center for Space Research/ Gordon Wells | 3925 West Braker Lane,<br>Suite 200<br>Austin, TX 78759-5321 | 512-232-7515 | gwells@csr.utexas.edu |
| West Texas Regional Poison Center/<br>Leo Artalejo | 4815 Alameda<br>El Paso, TX 79905 | 915-534-3800 | leoa@poisoncenter.org |
| **NATIONAL LEVEL** | | | |
| Agency for Toxic Substances and Diseases Registry | 4770 Buford Highway Northeast<br>Atlanta, GA 30341 | 800-232-4636 | cdcinfo@cdc.gov |
| American Association for Respiratory Care/ Tom Kallstrom | 9425 North MacArthur Boulevard, #100<br>Irving, TX 75063 | 972-243-2272 | kallstrom@aarc.org |
| American Association for the Treatment of Opioid Dependence/ Mark W. Parrino | 225 Varick Street, 4th Floor<br>New York, NY 10014 | 212-566-5555 | info@aatod.org |
| American Association of Kidney Patients | 2701 Rocky Point Drive, Suite 150<br>Tampa, FL 33607 | 800-749-2257 | info@aakp.org |
| American Association of Poison Control Centers/<br>Jim Hirt | 515 King Street,<br>Suite 510<br>Alexandria, VA 22314 | 703-894-1858 | info@aapcc.org |
| American Cancer Society - High Plains Division/ Kelly Headrick | 2433-A RidgePoint Drive<br>Austin, TX 78754 | 512-919-1806 | kelly.headrick@cancer.org<br>eRev@cancer.org |
| American Dental Association | 211 East Chicago Avenue<br>Chicago, IL 60611 | 312-440-2500 | http://www.ada.org/22.aspx |

| INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS<br>(that serve as an information clearinghouse or regularly interact with your agency) | | | |
|---|---|---|---|
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| American Diabetes Association/ Veronica dela Garza | 940 Research Boulevard, #50<br>Austin, TX 78759 | 512-472-9838 x6017 | AskADA@diabetes.org<br>vdelagarza@diabetes.org |
| American Lung Association/ Robbie Moore | 5926 Balcones Drive, Suite 100<br>Austin, TX 78721-4263 | 512-467-6753 | rmoore@breathehealthy.org<br>info@texaslung.org |
| American Nurses Credentialing Center | 8515 Georgia Avenue, Suite 400<br>Silver Spring, MD 20910-3492 | 800-284-2378 | kathy.chappell@ana.org |
| Association of Maternal and Child Health Programs/ Barbara Laur | 2030 M Street, Northwest,<br>Suite 350<br>Washington, DC 20036 | 202-775-0436 | blaur@amchp.org |
| Association of State and Territorial Health Officials | 2231 Crystal Drive, Suite 450<br>Arlington, VA 22202 | 202-371-9090 | agarcia@astho.org |
| American Veterinary Medical Association/ Julie Granstrom | 1931 North Meacham Road, Suite 100<br>Schaumburg, IL 60173-4360 | 800-248-2862 | jgranstrom@avma.org<br>info@avma.org |
| Bat Conservation International | P.O. Box 162603<br>Austin, TX 78716 | 512-327-9721 | http://www.batcon.org/index.php/media-and-info/about-bci/contact-bci.html.html |
| Centers for Disease Control and Prevention, Division of Cancer Prevention and Control, Cancer Surveillance Branch/ Christie Eheman | 4770 Buford Highway, MS K-53<br>Atlanta, GA 30341-3717 | 770-488-3245 | CEheman@cdc.gov |

| INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS<br>(that serve as an information clearinghouse or regularly interact with your agency) | | | |
|---|---|---|---|
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Children's Environmental Health Institute/ Janie D. Fields | P.O. Box 50342<br>Austin, TX 78763-0342 | 512-657-7405 | janie.fields@cehi.org |
| Council for State and Territorial Epidemiologists/ Pat McConnon | 2872 Woodcock Boulevard, Suite 303<br>Atlanta, GA 30341 | 770-458-3811 | pmcconnon@cste.org |
| Juvenile Diabetes Research Foundation | 26 Broadway<br>New York, NY 10004 | 800-533-2873<br>713-334-4400 | info@jdrf.org |
| Livestrong Foundation/ Andy Miller | 2201 East Sixth Street<br>Austin, TX 78702 | 877-236-8820 | andy.miller@livestrong.org |
| March of Dimes - National | 1275 Mamoroneck Avenue<br>White Plains, NY 10605 | 914-997-4488 | http://www.marchofdimes.com/contactus.html |
| Multiple Sclerosis Society - National | 733 Third Avenue<br>New York, NY 10017 | 800-344-4867 | http://www.nationalmssociety.org/ContactUs.aspx |
| National Association for Public Health Statistics and Information Systems/ Garland Land | 962 Wayne Avenue, Suite 701<br>Silver Spring, MD 20910 | 301-563-6001 | gland@naphsis.org |
| National Association of Community Health Centers/ Freda Mitchem | 7200 Wisconsin Avenue, Suite 210<br>Bethesda, MD 20814 | 301-347-0400 | Fmitchem@nachc.com |
| National Association of Social Workers | 750 First Street, Northeast, Suite 700<br>Washington, D.C. 20002-4241 | 202-408-8600 | media@naswdc.org |

| INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS<br>(that serve as an information clearinghouse or regularly interact with your agency) | | | |
|---|---|---|---|
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| National Association of State Alcohol/Drug Abuse Directors/ Rob Morrison | 1025 Connecticut Avenue, Northwest, Suite 605 Washington, D.C. 20036 | 202-293-0090 | rmorrison@nasadad.org |
| National Association of State Mental Health Program Directors/ Robert Glover | 66 Canal Center Plaza, Suite 302 Alexandria, VA 22314 | 703-739-9333 | bob.glover@nasmhpd.org |
| National Center for Substance Abuse & Child Welfare/ Kim Burgess | 4940 Irvine Boulevard, Suite 202 Irvine, CA 92620 | 714-505-3525 | ncsacw@cffutures.org |
| National Drowning Prevention Alliance/ Kristin Goffman | P.O. Box 1641 Idyllwild, CA 92549 | 951-659-8600 | Admin@NDPA.org |
| National Family Planning and Reproductive Health Association | 1627 K Street Northwest, 12th Floor Washington, D.C. 20005 | 202-293-3114 | info@nfprha.org |
| National Health Services Corporation/ Susan Salter | 5600 Fishers Lane, PKLN/8A-55 Rockville, MD 20857 | 301-594-4149 | Ssalter@hrsa.gov |
| National Hemophilia Foundation | 116 W. 32nd Street, 11th Floor New York, NY 10001 | 212-328-3700 | handi@hemophilia.org |
| National Medical Association/ Kweisi Mfume | 8403 Colesville Road, Suite 920 Silver Spring, MD 20910 | 202-347-1895 | execdir@nmanet.org |
| National Tanning Training Institute/ Rebecca Pray | P.O. Box 40079 Phoenix, AZ 85067 | 800-529-1101 | rpray@vpico.com |

| INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS<br>(that serve as an information clearinghouse or regularly interact with your agency) | | | |
|---|---|---|---|
| **Group or Association Name/Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| National Tattoo Association/ Curt Keck | 485 Business Park Lane Allentown, PA 18109-9120 | 610-433-7261 | curt@nationaltattoo.com |
| Office of National Drug Control Policy | P.O. Box 6000 Rockville, MD 20849 | 800-666-3332 | ondcp@ncjrs.org |
| Spina Bifida Association - National | 4590 Macarthur Boulevard, Northwest, Suite 250 Washington, D.C. 20007-4226 | 800-621-3141 202-944-3285 | sbaa@sbaa.org |
| Substance Abuse and Mental Health Services Administration | P.O. Box 2345 Rockville, MD 20847-2345 | 240-276-2000 | SAMHSAInfo@samhsa.hhs.gov |
| U.S. Department of Agriculture, Animal and Plant Health Inspection Service, Wildlife Services/ Dennis Slate | 59 Chenell Drive, Suite 7 Concord, NH 03301 | 603-223-9623 | SAMHSAInfo@samhsa.hhs.gov |
| U.S. Health and Human Services/ Office of the Inspector General | Office of Public Affairs, Cohen Building # 5541, 330 Independence Avenue Southwest Washington, D.C., 20201 | 202-619-1343 | paffairs@oig.hhs.gov |
| U.S. Health Resources and Services Administration | Parklawn Building 5600 Fishers Lane, Room 14-45 Rockville, MD 20857 | 301-443-3376 | comments@hrsa.gov |
| Western Center for the Application of Prevention Technology/ Julie Hogan | Mail Stop 279 University of Reno Reno, NV 89557 | 775-682-8542 | JHogan@casat.org |

| LIAISONS AT OTHER STATE AGENCIES AND INDEPENDENT BOARDS (with which your agency maintains an ongoing relationship, e.g., the agency's assigned analyst at the Legislative Budget Board, or attorney at the Attorney General's office) | | | |
|---|---|---|---|
| **Agency Name/Relationship/ Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Advisory Board of Athletic Trainers | P.O. Box 149347 Austin, Texas 78714-9347 | 512- 834-6615 | at@dshs.state.tx.us |
| Cancer Prevention and Research Institute of Texas/ Sandra Balderrama | 211 East 7th Street, Suite 300 Austin, TX 78701 | 512-463-3190 x104 | sbalderrama@cprit.state.tx.us |
| Commission on State Emergency Communications/ Paul Mallett | 333 Guadalupe Street Suite 2-212 Austin, TX 78701-3942 | 512-305-6911 | csecinfo@csec.texas.gov |
| Counsel on Sex Offender Treatment/ Allison Taylor | P.O. Box 149347 Austin , Texas 78714-9347 | 512-834-4530 | csot@dshs.state.tx.us |
| Governor's Commission for Women/ Leslie Guthrie | P.O. Box 12428 Austin, TX 78711 | 512-475-2615 | lguthrie@governor.state.tx.us women@governor.state.tx.us |
| Governor's EMS Trauma Advisory Council/ Vance Riley | 8333 Freedom Drive Pearland, TX 77581 | 281-997-5851 | vriley@ci.pearland.tx.us |
| Governor's Office/ Andria Franco | Office of the Governor P.O. Box 12428 Austin, TX 78711-2428 | 512-463-7582 | andria.franco@governor.state.tx.us |
| Health Professions Council/ John Monk | 333 Guadalupe Street, Suite 2-220 Austin, TX 78701 | 512-305-8550 | john.monk@hpc.state.tx.us |
| Legislative Budget Board/ Christy Havel | P.O. Box 12666 Austin, TX 78711-1266 | 512-463-1200 | christy.havel@lbb.state.tx.us |

| LIAISONS AT OTHER STATE AGENCIES AND INDEPENDENT BOARDS (with which your agency maintains an ongoing relationship, e.g., the agency's assigned analyst at the Legislative Budget Board, or attorney at the Attorney General's office) | | | |
|---|---|---|---|
| **Agency Name/Relationship/ Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Lieutenant Governor's Office/ Jamie Dudensing | P.O. Box 12068 Capitol Station Austin, TX 78711 | 512-463-0001 | jamie.dudensing@ltgov.state.tx.us |
| Office of the Attorney General | 209 W. 14th Street Austin, TX 78701 | 512-463-2100 | public.information@texasattorneygeneral.gov |
| Office of the Speaker/ Jennifer Deegan | P.O. Box 2910 Austin, TX 78768-2910 | 512-463-1546 | jennifer.deegan@speaker.state.tx.us |
| State Board of Examiners for Speech-Language Pathology and Audiology | 1100 West 49th Street Mail Code 1982 Austin, TX 78756 | 512-834-6627 | speech@dshs.state.tx.us |
| State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments | P.O. Box 149347 Austin , Texas 78714-9347 | 512-834-6784 | fdhi@dshs.state.tx.us |
| Texas Animal Health Commission/ Dee Ellis | 2105 Kramer Lane Austin, TX 78758 | 512-719-0700 | execdir@tahc.state.tx.us |
| Texas Board of Licensure for Professional Medical Physicists | P.O. Box 149347 Austin , TV 78714-9347 | 512-834-6655 | med_physicist@dshs.state.tx.us |
| Texas Board of Nursing/ Kathy Thomas | 333 Guadalupe #3-460 Austin, TX 78701 | 512-305-7400 | Kathy.Thomas@bon.state.tx.us |
| Texas Board of Orthotics and Prosthetics | P.O. Box 149347 Austin , TX 78714-9347 | 512-834-4520 | op@dshs.state.tx.us |
| Texas Commission on Environmental Quality | P.O. Box 13087 Austin, TX 78711 | 512-239-1000 | ac@tceq.state.tx.us |
| Texas Correctional Office on Offender with Medical and Mental Impairments/ April Zamora | 8712 Shoal Creek Boulevard, Suite 280 Austin, TX 78757 | 512-465-5100 | tcoommi@tdcj.state.tx.us |

| LIAISONS AT OTHER STATE AGENCIES AND INDEPENDENT BOARDS (with which your agency maintains an ongoing relationship, e.g., the agency's assigned analyst at the Legislative Budget Board, or attorney at the Attorney General's office) | | | |
|---|---|---|---|
| **Agency Name/Relationship/ Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Council on Alzheimer's Disease and Related Disorders/ Susan Ristine | 1100 West 49th Street<br>Mail Code 1945<br>Austin, TX 78756 | 512-458-7534 | susan.ristine@dshs.state.tx.us |
| Texas Department of Agriculture | 1700 North Congress Avenue<br>Austin, TX 78701 | 512-463-7476<br>800-835-5832 | regulatory@tda.state.tx.us |
| Texas Department of Criminal Justice/ Brad Livingston | P.O. Box 99<br>Huntsville, TX 77342 | 936-437-2101 | Brad.livingston@tdcj.state.tx.us |
| Texas Department of Housing and Community Affairs/ Brooke Boston | P.O. Box 13941<br>Austin, TX 78711 | 512-475-1762 | info@tdhca.state.tx.us |
| Texas Department of Rural Affairs/ Charles Stone | 1700 North Congress Avenue, Suite 220<br>Austin, TX 78701 | 512-936-6701 | tdra@tdra.texas.gov |
| Texas Department of Transportation – Traffic Operations Division/ Carol T. Rawson, Sam Sinclair | 125 East 11th Street<br>Austin, TX 78701<br><br>118 East Riverside<br>Austin, TX 78704 | 512-486-5780<br>512-416-3200<br>512-416-3276 | carol.rawson@txdot.gov<br>sam.sinclair@txdot.gov |
| Texas Division of Emergency Management/ Nim Kidd | P.O. Box 4087<br>Austin, TX 78773-0001 | 512-424-2443 | Nim.kidd@txdps.state.tx.us |
| Texas Education Agency | 1701 North Congress<br>Austin, TX 78701 | 512-463-9734 | teainfo@tea.state.tx.us |
| Texas Funeral Service Commission/ Donna Potter | P.O. Box 12217<br>Austin, TX 78711 | 512-936-2474 | info@tfsc.state.tx.us |

| LIAISONS AT OTHER STATE AGENCIES AND INDEPENDENT BOARDS (with which your agency maintains an ongoing relationship, e.g., the agency's assigned analyst at the Legislative Budget Board, or attorney at the Attorney General's office) | | | |
|---|---|---|---|
| **Agency Name/Relationship/ Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Geographic Information Council/ Rob Aanstoos | P.O. Box 13564 Austin, TX 78711-3564 | 512-463-7314 | rob.aanstoos@dir.texas.gov |
| Texas Higher Education Coordinating Board/ Alberto Contreras | Student Services, Loan Program Operations, 1200 East Anderson Lane Austin, TX 78752 | 512-427-6340 | alberto.contreras@thecb.state.tx.us |
| Texas Juvenile Justice Department | P.O. Box 13547 Austin, TX 78711 | 512-424-6700 | info@tjpc.state.tx.us |
| Texas Midwifery Board | Mail Code 1982 P.O. Box 149347 Austin, TX 78714-9347 | 512-834-4523 | midwifery@dshs.state.tx.us |
| Texas Parks and Wildlife/ Ross Melinchuk | 4200 Smith School Road Austin, TX 78744 | 512-389-4800 | ross.melinchuk@tpwd.state.tx.us |
| Texas State Board of Dental Examiners/ Lisa Jones | 333 Guadalupe Street, Tower 3, Suite 800 Austin, TX 78701-3942 | 512-463-6400 | lisa.jones@tsbde.state.tx.us |
| Texas Medical Board/ Mari Robinson | 333 Guadalupe Street, Tower 3, #610 Austin, TX 78701 | 512-305-7017 | verifcic@tmb.state.tx.us |
| Texas Department of Aging and Disability Services | 701 West 51st Street Austin, TX 78751 | 512-438-3011 | mail@dads.state.tx.us |
| Texas Department of Assistance and Rehabilitative Services | 4800 North Lamar Boulevard Austin, TX 78756 | 512-424-4000 | DARS.Inquiries@dars.state.tx.us |
| Texas Department of Family and Protective Services | 701 West 51st Street Austin, TX 78751 | 512-438-4800 | https://www.dfps.state.tx.us/Contact_Us/Default.asp |

| LIAISONS AT OTHER STATE AGENCIES AND INDEPENDENT BOARDS (with which your agency maintains an ongoing relationship, e.g., the agency's assigned analyst at the Legislative Budget Board, or attorney at the Attorney General's office) | | | |
|---|---|---|---|
| **Agency Name/Relationship/ Contact Person** | **Address** | **Telephone** | **E-mail Address** |
| Texas Health and Human Services Commission | 4900 North Lamar Boulevard Austin, TX 78751-2316 | 512-424-6500 | contact@hhsc.state.tx.us |
| Texas Secretary of State | P.O. Box 12887 Austin, TX 78711-2887 | 512-463-5600 | ucc_assist@sos.state.tx.us |
| Texas State Board of Examiners of Dietitians | P.O. Box 149347 Austin , TX 78714-9347 | 512-834-6601 | dietitian@dshs.state.tx.us |
| Texas State Board of Examiners of Marriage and Family Therapists | P.O. Box 149347 Austin , TX 78714-9347 | 512-834-6657 | mft@dshs.state.tx.us |
| Texas State Board of Examiners of Professional Counselors | P.O. Box 149347 Austin, Texas 78714-9347 | 512-834-6658 | lpc@dshs.state.tx.us |
| Texas State Board of Pharmacy/ Melinda Uballe | William P. Hobby Building Tower 3, Suite 600, 333 Guadalupe Street Austin, TX 78701 | 512-305-8022 | Melinda.uballe@tsbp.state.tx.us |
| Texas State Board of Social Work Examiners/ Carol Miller | 1100 West 49th Street Mail Code 1982 Austin, TX 78756 | 512-719-3521 | lsw@dshs.state.tx.us |
| Texas State Board of Veterinary Medical Examiners/ Loris Jones | 333 Guadalupe Street Tower III, Suite 810 Austin, Texas 78701 | 512-305-7555 | vet.board@tbvme.state.tx.us |
| Texas Traumatic Brain Injury Advisory Council/ Bettie Beckworth | 4900 North Lamar Boulevard, Mail Code 1542 Austin, TX 78751 | 512-458-7111 x6328 | Bettie.Beckworth@hhsc.state.tx.us |

## XI. ADDITIONAL INFORMATION

**A. Texas Government Code, Sec. 325.0075 requires agencies under review to submit a report about their reporting requirements to Sunset with the same due date as the SER. Include a list of each report that the agency is required by statute to prepare and an evaluation of the need for each report based on whether factors or conditions have changed since the statutory requirement was in place. If the list is longer than one page, please include it as an attachment.**

The Department of State Health Services (DSHS) has over 75 reports required by statute, including 38 budget and financial reports. See Attachment 21 for a complete list of all reports.

**B. Has the agency implemented statutory requirements to ensure the use of "first person respectful language"? Please explain and include any statutory provisions that prohibits these changes.**

Section 531.0227, Texas Government Code, requires the Health and Human Services (HHS) Executive Commissioner to ensure that the Health and Human Services Commission (HHSC) and the HHS System agencies "use the terms and phrases listed as preferred under the person first respectful language initiative in Chapter 392 [of the Government Code] when proposing, adopting, or amending the commission's or agency's rules, reference materials, publications, and electronic media." Section 531.0227 was effective September 1, 2011.

This statutory directive has been implemented at DSHS through the Executive Commissioner's instructions to HHSC and the HHS System agencies and through specific DSHS' program initiatives. Specific examples include the following.

**Guidance Memorandum**

The Executive Commissioner issued HHS Guidance Memorandum GM-12-002, *Person First Respectful Language in Communications*, in December 2011. In it, the Executive Commissioner directs each agency to use appropriate person first terms and phrases when proposing, adopting, or amending agency rules, reference materials, publications, and electronic media. Executive management at HHSC and the HHS System agencies was notified directly of GM-12-002. In addition, the release of GM-12-002 was featured in *The Connection*, the HHS System newsletter available to staff at HHSC and the HHS System agencies. GM-12-002 was last updated in January 2013.

**Communications to Staff**

*The Connection* highlighted the legislation underlying section 531.0227 – House Bill 1481, 82nd Legislature, Regular Session, 2011 – and noted efforts of DADS and other agencies to encourage person first respectful language. A second article noted the passage of H.B. 1481 and the new requirements for HHSC and the HHS System agencies.

**Rule Review**

As DSHS develops new rules or proposes to amend existing rules, the originating program and legal staff review to ensure the use of preferred terms and compliance with H.B. 1481.

**HHS Style Guide**

DSHS uses the HHS Style Guide for official communication documents. HHSC's Communications staff updated the *HHS Style Guide for Consumer Materials* to include instructions on the use of person first respectful language. The style guide is intended to ensure consistency in the materials written for consumers of HHS services by the agency or contractors providing those services.

**DSHS Program Initiatives**

Examples of DSHS program activities to implement H.B. 1481 include the following.

- The Family and Community Health Services (FCHS) Division, Specialized Health Services Section added an activity to the Federal Title V fiscal year 2013 grant application activity plan, which states: Promote use of "People-First" language and appropriate languages, literacy levels, and cultural approaches in all communications regarding Children and Youth with Special Health Care Needs families.
- The FCHS Division, Children with Special Health Care Needs Services Program staff as well as community-based contractors have given presentations on this subject.
- The Regulatory Services Division revised Title 25, Texas Administrative Code, Chapter 133, Hospital Licensing, to include the preferred terms for persons with intellectual disabilities.
- The Mental Health and Substance Abuse Services Division sent out a broadcast message to all local mental health authorizes and numerous stakeholder groups regarding implementation of the person first respectful language requirement. Since then, all new and amended rules reflect the person first respectful language.

DSHS has not encountered any statutory prohibition on using person first respectful language.

**C. Fill in the following chart detailing information on complaints regarding your agency. Do not include complaints received against people or entities you regulate. The chart headings may be changed if needed to better reflect your agency's practices.**

| Department of State Health Services<br>Exhibit 15: Complaints Against the Agency — Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| **Number of complaints received*** | 1,304 | 1,168 |
| **Number of complaints resolved*** | 1,329 | 1,178 |
| **Number of complaints dropped/found to be without merit **** | See note below | See note below |

| Department of State Health Services<br>Exhibit 15: Complaints Against the Agency — Fiscal Years 2011 and 2012 | | |
|---|---|---|
| | **FY 2011** | **FY 2012** |
| **Number of complaints pending from prior years** | 25 | 22 |
| **Average time period for resolution of a complaint** | 3 days | 7 days |

*Number of complaints received and resolved: These numbers do not include the universe of complaints received throughout the agency, which were not tracked centrally during this time period. During fiscal years 2011 and 2012, the Center for Consumer and External Affairs, Customer Service; the Mental Health and Substance Abuse Division, Consumer Services and Rights Protection; and the Family and Community Health Services Division, Women, Infants, and Children (WIC) Special Supplemental Nutrition Program, tracked complaints through the Health and Human Services Enterprise Administrative Reporting and Tracking (HEART) database. State Hospitals did not begin tracking complaints in HEART until September 1, 2012 and the Vital Statistics Unit will not begin tracking until September 1, 2013.

**Number of complaints dropped/found to be without merit: DSHS programs have historically used different findings for complaint resolution and have not consistently used "dropped/found without merit." Effective March 1, 2013, HEART was modified and program staff was trained for consistent use of "substantiated" to indicate that the agency expectations were not met.

**D. Fill in the following chart detailing your agency's Historically Underutilized Business (HUB) purchases. See Exhibit 16 Example or click here to link directly to the example.**

| Department of State Health Services<br>Exhibit 16: Purchases from HUBs<br>FISCAL YEAR 2010 | | | | | |
|---|---|---|---|---|---|
| **Category** | **Total $ Spent** | **Total HUB $ Spent** | **Percent** | **Agency Specific Goal *** | **Statewide Goal** |
| Heavy Construction | $8,131 | $4,838 | 59.5% | 11.9% | 11.9% |
| Building Construction | $253,953 | $30,495 | 12.0% | 26.1% | 26.1% |
| Special Trade | $13,277,250 | $3,664,284 | 27.5% | 57.2% | 57.2% |
| Professional Services | $21,065,112 | $747,412 | 3.5% | 20.0% | 20.0% |
| Other Services | $94,089,700 | $31,067,193 | 33.0% | 33.0% | 33.0% |
| Commodities | $226,483,908 | $12,511,875 | 5.5% | 12.6% | 12.6% |
| **TOTAL** | **$355,178,057** | **$48,026,100** | **13.5%** | | |

| FISCAL YEAR 2011 | | | | | |
|---|---|---|---|---|---|
| **Category** | **Total $ Spent** | **Total HUB $ Spent** | **Percent** | **Agency Goal** | **Statewide Goal** |
| Heavy Construction | $17,427 | $0 | 0% | 11.9% | 11.9% |
| Building Construction | $159,414 | $62,477 | 39.2% | 26.1% | 26.1% |
| Special Trade | $15,759,515 | $2,655,396 | 16.8% | 57.2% | 57.2% |
| Professional Services | $23,227,592 | $698,560 | 3.0% | 20.0% | 20.0% |
| Other Services | $87,860,819 | $34,025,899 | 38.7% | 33.0% | 33.0% |
| Commodities | $213,897,986 | $20,056,231 | 9.4 | 12.6% | 12.6% |
| **TOTAL** | **$340,922,754** | **$57,498,566** | **16.9%** | | |

| FISCAL YEAR 2012 | | | | | |
|---|---|---|---|---|---|
| **Category** | **Total $ Spent** | **Total HUB $ Spent** | **Percent** | **Agency Goal** | **Statewide Goal** |
| Heavy Construction | $18,801 | $2,363 | 12.6% | 11.2% | 11.2% |
| Building Construction | $161,603 | $24,209 | 15.0% | 21.1% | 21.1% |
| Special Trade | $13,575,955 | $4,583,466 | 33.8% | 32.7% | 32.7% |
| Professional Services | $20,973,939 | $479,383 | 2.3% | 23.6% | 23.6% |
| Other Services | $88,035,135 | $34,539,263 | 39.2% | 24.6% | 24.6% |
| Commodities | $221,539,343 | $13,708,228 | 6.2% | 21.0% | 21.0% |
| **TOTAL** | **$344,304,779** | **$53,336,914** | **15.5%** | | |

**E. Does your agency have a HUB policy? How does your agency address performance shortfalls related to the policy? (Texas Government Code, Sec. 2161.003; TAC Title 34, Part 1, rule 20.15b)**

Yes. DSHS has a policy on the use of Historically Underutilized Businesses (HUBs). DSHS adopted the Comptroller of Public Accounts (CPA) HUB rules by reference. The policy mandates that DSHS shall make a good faith effort to utilize HUBs or minority businesses in contracts for construction, services, and commodities; and to encourage the use of HUBs by implementing these policies through race-, ethnic-, and gender-neutral means.

DSHS is committed to promoting full and equal business opportunities for all businesses in state contracting in accordance with the methodology recommended for HUB goal attainment as a result of the State of Texas Disparity Study:

DSHS policy on the utilization of HUBs is related to all contracts with an expected value of $100,000 or more, and whenever practical, in contracts less than $100,000. It is the policy of DSHS and its contractors to accomplish these goals either through contracting directly with HUBs or indirectly through subcontracting opportunities. DSHS and its contractors shall make a good faith effort to meet or exceed the goals and assist HUBs in receiving a portion of the total contract value of all contracts that DSHS expects to award in a fiscal year.

In order to address performance shortfalls, DSHS monitors its contracts on a monthly basis to determine the level of HUB and minority participation. DSHS strives to eliminate shortfalls by analyzing the expenditures and payments made to its vendors, improve the expertise in evaluating contract opportunities for HUBs or minority firms, and assist each program/division to implement good faith efforts to meet or exceed the goals. Because most of the DSHS contracts are highly specialized, DSHS is continuously demonstrating its commitment to the use of HUBs by:

- participating in external Economic Opportunity Forums and related HUB outreach events statewide;
- hosting internal HUB forums providing HUBs the opportunity to give business presentations to agency management, purchasing, and HUB staff;
- identifying and developing opportunities for HUBs;
- sponsoring and assisting in the development of mentor-protégé relationships with Prime Contractors and HUB;
- recruiting new HUBs/minority vendors for potential contracting opportunities in the procurement categories where there has been minimal HUB utilization;
- offering HUBs assistance and training regarding state procurement procedures;
- assisting and soliciting minority firms for current and new contract opportunities;
- assisting HUBs with the certification and re-certification process for the Statewide HUB Program; and
- encouraging HUBs to register on the CPA's Centralized Master Bidders List.

**F. For agencies with contracts valued at $100,000 or more: Does your agency follow a HUB subcontracting plan to solicit bids, proposals, offers, or other applicable expressions of interest for subcontracting opportunities available for contracts of $100,000 or more? (Texas Government Code, Sec. 2161.252; TAC Title 34, Part 1, rule 20.14)**

Yes, DSHS has an established process to ensure that the agency considers HUB goals when it enters into a contract with an expected value of $100,000 or more. DSHS makes a determination whether or not subcontracting opportunities are probable under the contract before DSHS solicits bids, proposals, offers, or other applicable expressions of interest. DSHS' HUB Program Office reviews the solicitation document prior to advertisement to ensure that the following occur.

- It allows for the greatest amount of competition possible.
- The bonding and insurance requirements are reasonable.

- It lists potential subcontracting opportunities.
- It lists the HUB percentage participation goal.
- It lists the prime contractor's performance requirements related to the HUB Program.
- It includes HUB subcontracting plan requirements.

In addition, the DSHS HUB Program Office works with the DSHS division/program staff to administer comprehensive HUB subcontracting plans that include:

- providing an overview of the HUB subcontracting plan requirements during the vendor conference;
- how and when the HUB Program Office evaluates responses for compliance;
- post-award meetings with the selected vendor which details the contractor performance expectations related to fulfilling the HUB requirements of the contract; and
- ongoing progress assessment monitoring and reporting to ensure the vendor maintains the agreed upon HUB participation percentage commitment, when applicable.

During the solicitation process, all respondents are required to make a good faith effort to complete a HUB subcontracting plan. If the respondent does not make a good-faith effort or if a subcontracting plan is not submitted or is incomplete, the proposal/bid will be disqualified. If the vendor will be using subcontractors, then the vendor is required to demonstrate the effort that was made to solicit a certified HUB subcontractor. DSHS encourages vendors to utilize the CPA HUB directory for the inclusion of HUBs in its contract opportunities. If the subcontractor selected is not a certified HUB, the respondent must provide written justification of their selection process.

In addition to the above efforts, the HHSC Enterprise Contracts and Procurement Services (ECPS; Purchasing Section) assists in making a good-faith effort to ensure HUBs are included in the procurement solicitation processes.

**G. For agencies with biennial appropriations exceeding $10 million, answer the following HUB questions.**

| | **Response / Agency Contact** |
|---|---|
| 1. Do you have a HUB coordinator? (Texas Government Code, Sec. 2161.062; TAC Title 34, Part 1, rule 20.26) | Yes, DSHS HUB Coordinator:<br>Shawn Constancio<br>4405 North Lamar Blvd., Bldg. #1<br>Austin, Texas 78756<br>Phone (512) 206-4543<br>Fax (512) 206-4605<br>shawn.constancio@hhsc.state.tx.us |

| | Response / Agency Contact |
|---|---|
| 2. Has your agency designed a program of HUB forums in which businesses are invited to deliver presentations that demonstrate their capability to do business with your agency? (Texas Government Code, Sec. 2161.066; TAC Title 34, Part 1, rule 20.27) | Yes, DSHS and Health and Human Services agencies conduct an internal HUB forum on a monthly basis where the agencies invite HUB vendors to attend and give a presentation regarding their products, staff, and core capabilities. DSHS also discusses potential contracting opportunities with the vendors. DSHS invites procurement, program, HUB staff, and related decision-makers to attend these forums. |
| 3. Has your agency developed a mentor-protégé program to foster long-term relationships between prime contractors and HUBs and to increase the ability of HUBs to contract with the state or to receive subcontracts under a state contract? (Texas Government Code, Sec. 2161.065; TAC Title 34, Part 1, rule 20.28) | Yes, DSHS has a mentor-protégé program. It is the agency's intent to facilitate the creation of effective working relationships between leaders of mature established companies and emerging minority and women businesses in order for the latter to benefit from the knowledge and experience of the established firms. |

**H. Fill in the chart below detailing your agency's Equal Employment Opportunity (EEO) statistics.[1]**

| Department of State Health Services<br>Exhibit 17: Equal Employment Opportunity Statistics | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fiscal Year 2009 | | | | | | | |
| Job Category | Total Position | Minority Workforce Percentage | | | | | |
| | | Black | | Hispanic | | Female | |
| | | Agency | Civilian Labor Force % | Agency | Civilian Labor Force % | Agency | Civilian Labor Force % |
| Officials/ Administration | 378 | 7.7% | 7.5% | 18.0% | 21.1% | 55.0% | 37.5% |
| Professional | 4,458 | 10.3% | 9.7% | 19.0% | 18.8% | 65.8% | 53.3% |
| Technical | 1,125 | 15.6% | 13.9% | 28.0% | 27.7% | 71.9% | 53.9% |
| Administrative Support | 1,640 | 14.3% | 12.7% | 32.1% | 31.9% | 88.7% | 67.1% |
| Service Maintenance | 4,347 | 27.8% | 14.1% | 31.1% | 49.9% | 56.7% | 39.1% |
| Skilled Craft | 331 | 6.3% | 6.6% | 31.1% | 46.3% | 3.3% | 6.0% |

-Source Data: Fiscal Year 2009 from Human Resources/PeopleSoft 08/31/2009

-The Service/Maintenance category includes three distinct occupational categories: Service/Maintenance, Para-Professionals, and Protective Services. Protective Service Workers and Para-Professionals are no longer reported as separate groups. Please submit the combined Service/Maintenance category totals, if available.

-Civilian Labor Force Figures from Texas Workforce Commission

[1] The Service/Maintenance category includes three distinct occupational categories: Service/Maintenance, Para-Professionals, and Protective Services. Protective Service Workers and Para-Professionals are no longer reported as separate groups. Please submit the combined Service/Maintenance category totals, if available.

| Department of State Health Services<br>Exhibit 17: Equal Employment Opportunity Statistics | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fiscal Year 2010 | | | | | | | |
| Job Category | Total Position | Minority Workforce Percentage | | | | | |
| | | Black | | Hispanic | | Female | |
| | | Agency | Civilian Labor Force % | Agency | Civilian Labor Force % | Agency | Civilian Labor Force % |
| Officials/ Administration | 380 | 8.9% | 7.5% | 17.9% | 21.1% | 55.3% | 37.5% |
| Professional | 4,644 | 10.4% | 9.7% | 19.2% | 18.8% | 66.6% | 53.3% |
| Technical | 1,124 | 16.5% | 13.9% | 28.6% | 27.7% | 71.9% | 53.9% |
| Administrative Support | 1,577 | 14.7% | 12.7% | 32.5% | 31.9% | 88.3% | 67.1% |
| Service Maintenance | 4,117 | 29.0% | 14.1% | 33.2% | 49.9% | 55.8% | 39.1% |
| Skilled Craft | 325 | 6.5% | 6.6% | 30.2% | 46.3% | 2.8% | 6.0% |

- Source Data: Fiscal Year 2010 from Human Resources/PeopleSoft 08/31/2010

-The Service/Maintenance category includes three distinct occupational categories: Service/Maintenance, Para-Professionals, and Protective Services. Protective Service Workers and Para-Professionals are no longer reported as separate groups. Please submit the combined Service/Maintenance category totals, if available.

-Civilian Labor Force Figures from Workforce Commission

| Department of State Health Services<br>Exhibit 17: Equal Employment Opportunity Statistics | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fiscal Year 2011 | | | | | | | |
| Job Category | Total Position | Minority Workforce Percentage | | | | | |
| | | Black | | Hispanic | | Female | |
| | | Agency | Civilian Labor Force % | Agency | Civilian Labor Force % | Agency | Civilian Labor Force % |
| Officials/ Administration | 371 | 9.2% | 9.0% | 19.4% | 19.5% | 55.3% | 39.4% |
| Professional | 4,607 | 10.8% | 11.3% | 19.3% | 17.4% | 66.7% | 59.1% |
| Technical | 1,096 | 17.2% | 14.2% | 29.9% | 21.6% | 72.0% | 41.5% |
| Administrative Support | 1,521 | 15.7% | 13.6% | 33.6% | 30.5% | 88.3% | 65.5% |

| Department of State Health Services<br>Exhibit 17: Equal Employment Opportunity Statistics | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fiscal Year 2011 | | | | | | | |
| Job Category | Total Position | Minority Workforce Percentage | | | | | |
| | | Black | | Hispanic | | Female | |
| | | Agency | Civilian Labor Force % | Agency | Civilian Labor Force % | Agency | Civilian Labor Force % |
| Service Maintenance | 4,076 | 28.2% | 14.7% | 33.0% | 48.2% | 55.0% | 40.8% |
| Skilled Craft | 321 | 5.6% | 6.4% | 29.6% | 47.4% | 4.0% | 4.2% |

-Source Data: Fiscal Year 2011 from Human Resources/PeopleSoft 08/31/2011

-The Service/Maintenance category includes three distinct occupational categories: Service/Maintenance, Para-Professionals, and Protective Services. Protective Service Workers and Para-Professionals are no longer reported as separate groups. Please submit the combined Service/Maintenance category totals, if available.

-Civilian Labor Force Figures from 2011-2012 EEO and Minority Hiring Practices Report prepared by Workforce Commission, 01/2013.

**I. Does your agency have an equal employment opportunity policy? How does your agency address performance shortfalls related to the policy?**

Yes. The Health and Human Services (HHS) System policy for equal employment opportunity is published in the HHS Human Resource Manual, Chapter 16, Equal Employment Opportunity.

The HHSC Civil Rights Office (CRO) reviews and analyzes workforce utilization data. The CRO provides consultation and information related to equal employment opportunity issues and concerns. The CRO provides reports, e.g., personnel actions, new hire data and complaint data, to management for their review and action as appropriate. The CRO provides training tailored to address specific equal employment issues. Employees who violate the HHS System policy on equal employment are subject to disciplinary action, including termination.

## XII. AGENCY COMMENTS

The passage of H.B. 2292, in 2003, established a clear directive to transform the State's approach to the delivery of health and human services, with a particular focus on addressing the following issues.

- Access to services for individuals with complex health needs that required assistance from multiple agencies.
- Lack of integrated health and human services programs and agency policies.
- Redundant and/or inefficient administrative structures.
- Blurred lines of accountability.

Through the enactment of H.B. 2292, 12 stand-alone agencies were consolidated into an integrated system of four new departments under the leadership of the Texas Health and Human Services Commission (HHSC).

Today, nearly a decade post-consolidation, a coordinated Health and Human Services (HHS) System services exists. Although continued improvements may be needed in areas, progress on addressing the issues originally identified can be seen in a myriad of ways, as highlighted by the following examples.

- **Improved Service Quality and Accessibility.** Integrated programs result in improved community health. For example, the Department of State Health Services (DSHS) developed a single agency focus on physical and behavioral health issues emphasizing multi-program collaboration to improve efficiency and enhance services. Also, through a collaborative effort, HHSC and DSHS promote the benefits of the Women's Health Program and the Department of Aging and Disability Services (DADS), the Department of Family and Protective Services (DFPS), and DSHS continue to work together to improve services in HHS-operated facilities, such as State Supported Living Centers and State Hospitals.

  Integrating service delivery among physical and behavioral health providers improves outcomes. As a means to guide current and future planning and decision making, DSHS, in conjunction with external stakeholder efforts, developed a comprehensive approach to service integration by linking behavioral and physical health services. DSHS actively encourages the use of primary health care provision as a site for early screening and diagnosis of behavioral health problems.

  Meeting the demand for services is a perennial challenge facing the HHS System. Although waiting and interest lists for programs and services remain long, the ability to consolidate funding requests to address waiting lists and to request those funds as HHS System priorities has resulted in unprecedented levels of new funding to address interest lists, especially for waiver services.

  Managing long-term care services through one agency, DADS, leads to greater flexibility for individuals and families seeking services. For instance, previously some individuals rose to the top of a waiting list for one program, only to learn that another agency's waiver program was more appropriate for their needs than the waiver service for which they had

originally applied. Unfortunately, sometimes that meant that the client would have to start over at the bottom of another program's list. DADS now identifies, provides services, and/or places the person on the most appropriate waiver list for meeting their needs.

Better alignment of guardianship responsibilities protects the public. The transfer of guardianship responsibilities to DADS reinforced DFPS' primary role of investigating and serving adults in need of protection. DADS' expertise with long-term services and support programs for persons who are older and for adults with disabilities made it the appropriate agency for assuming guardianship responsibilities. Transferring this program removed any appearance of conflict of interest for DFPS staff in assessing and providing services for individuals in need of guardianship. As a result of coordinated DADS and DFPS efforts, the transfer of the guardianship program was completed with no disruption in services to individuals served.

- **Strengthening Children's Services.** An integrated system allows for a comprehensive approach to improve children's health care. Three divisions within DSHS, along with the regional Education Services Centers, combined efforts and resources to promote a coordinated approach to improving children's physical and behavioral health. The comprehensive approach includes coordinated school health, obesity prevention, suicide prevention, mental health awareness, diabetes prevention and care, and abstinence education activities. In 2008, DFPS worked with HHSC to launch STAR Health, the Medicaid managed care plan for children in foster care. Under contract with HHSC, STAR Health coordinated oversight of psychotropic medication utilization and use of psychotropic medications decreased. Additionally, the Health Passport was developed as an electronic health information system that provides information about prescribed psychotropic medications and is used as a primary source for the Psychotropic Medications Utilization Review process.

  Interagency efforts reduce psychotropic medications use for foster children. Soon after the consolidation of HHS agencies, concerns arose about possible overuse of psychotropic medications with the foster care population. DFPS and DSHS worked together using the services of a child psychiatrist to assess prescribing practices, develop prescribing guidelines, and recommend a process for ongoing clinical reviews of the use of psychotropic medications in the treatment of children in foster care.

  Consolidation leads to enhanced support for Early Childhood Intervention (ECI). Before consolidation, ECI, as a small stand-alone agency, struggled with addressing specialized tasks such as assessing the implications of rules and setting rates. Now, as a division within the Department of Assistive and Rehabilitative Services (DARS) and the integrated HHS System, ECI receives valuable support on such matters as rules, rates, and state Medicaid plan amendments.

- **Efficient and Effective Service Delivery.** Unifying web support for blind and rehabilitation services replaced two redundant legacy agency systems, and reduces the technical support, need for modifications, and costs for hardware, software, and related maintenance. Using a single system also enhances consistency among programs, because program changes and modifications will now be applied to only one application, rather than the prior multiple

applications. Eliminating the redundant rules of DARS legacy agencies resulted in the elimination of more than 100 redundant or unnecessary administrative rules from the legacy agencies.

Consolidated pharmaceutical purchasing for the DSHS Pharmacy Branch, DSHS State Hospitals, and DADS State Supported Living Centers saves millions of dollars annually in medication and medical supplies costs. Also, consolidated support services for such facilities save millions in personnel, operations, and supply costs for both DADS and DSHS.

- **Improving Information Accessibility Across the HHS System.** Coordinating long-term care licensing and regulatory activities yields coordinated, consistent, and direct oversight. Responsibility for long-term services and supports previously was split among DADS' three legacy agencies. The services and supports provided by the three agencies served various client populations. Many of the same regulatory issues were encountered for these services and supports. The agencies often addressed these issues in different ways and with limited coordination.
- **Adopting More Cost-Effective Business Practices.** House Bill 2292 assigned HHSC responsibility for delivering administrative services for the HHS System. Examples include centralized human resource services, civil rights, and support services for regional offices. These improvements saved millions in overhead costs and resulted in consistent policies, practices, and services.

In addition to the benefits of consolidation across the HHS System, DSHS programs and service recipients have benefited from the consolidation of public health and behavioral health services in a single agency. As a result of H.B. 2292, DSHS is responsible for addressing a variety of health issues that face Texans, including: mental illness, substance abuse, chronic disease, infectious disease, emergency response, food safety, children's health, and access to health care. Many of these issues are inter-related, thus, having a single state agency focused on them provides for improved coordination of care across various fields of practice. Additionally, DSHS manages a large number of licensing programs to protect the public's health, including regulation of healthcare facilities, professions, and drugs and medical devices.

Since consolidation occurred, DSHS has managed and responded to various public health and behavioral health issues and challenges. Additionally, the agency is aware of current and future issues that may have an impact on programs, services, employees, and service recipients. A few of these are mentioned below.

- **Prevent and Prepare for Health Threats.** Over the past several years, DSHS has been reminded how suddenly health challenges can develop into threats. The appearance of the novel H1N1 virus demonstrated how rapidly a pandemic could develop. While public health capacity was ultimately successful in its response, the development of a new threat from a quickly spreading infectious disease is inevitable. The West Nile virus outbreak in 2012 also challenged the response efforts of DSHS and local health departments; however, lessons learned from those experiences have resulted in improved reporting and testing processes. Food-borne illnesses also present a threat to the public's health. Within the past several

years, outbreaks of salmonella on both domestic peanuts and imported produce have reinforced the importance of protecting the food supply. DSHS regulatory and public health services are integrally involved in protecting Texans from food-borne illnesses.

- **Capacity to Improve Community Health.** The steady trend upward of obesity reminds us of the importance of increasing efforts to reduce its incidence and thereby reduce the cost of chronic disease to the economy. Tuberculosis and vaccine preventable diseases such as pertussis persist in Texas. Access to appropriate care and education throughout the life course helps reduce risks and improve outcomes. DSHS is committed to maintaining efforts to reduce the incidence of chronic and infectious diseases.

  Giving children a good start in life is essential. The rates of prematurity and infant mortality have increased in recent years. These rates and the associated healthcare costs can be reduced through targeted and evidence-based interventions. DSHS is working with community stakeholders, healthcare providers, and insurance companies to improve birth outcomes and maternal and infant mortality in Texas.

  Additional funding appropriated by the 83rd Legislature, Regular Session, 2013, will allow an expansion in the array of women's health services. With an emphasis on preventive and primary care, the expanded primary healthcare program will provide more women with access to well women checks, breast and cervical cancer screenings, prenatal care, wellness education, and family planning.

- **Evolving Healthcare Environment.** As the population of Texas grows, and changes in state and federal healthcare policy and resources evolve, the profile of persons in need of government-funded public health and primary health services is shifting. Healthcare reform implementation in 2014 presents opportunities for DSHS to redefine its role in the Texas healthcare system. Although coverage for health care will expand in the future, healthcare costs will continue to increase without action to prevent or mitigate certain diseases and conditions. DSHS must continue to use public health strategies, data, and other interventions to improve health and decrease healthcare costs. Healthcare reform will have a significant impact on the agency's structure and programs. DSHS is currently evaluating the impact of provisions such as the new federal high-risk insurance pool, insurance subsidies, Medicaid changes and potential impacts on licensing of professionals and facilities.

- **Recovery for Persons with Substance Use Disorders and/or Mental Illness.** Mental illness and substance abuse remain challenges for Texas families and communities. Texas made significant progress in the 80th and 81st Legislative sessions by supporting State Hospitals and increasing funding for mental health services in communities. These investments in mental health services reduce the burden on communities by serving mentally ill individuals in more appropriate settings than emergency rooms and local jails. Additionally, the Medicaid substance abuse services benefit endorsed by the 81st Legislature is helping

treatment providers draw on another resource to ensure effective treatment is available to Texans.

Most recently, a combination of an increased appropriation from the 83rd Legislature and federal dollars will provide opportunities for innovation and allow program expansion to address waiting lists and other unmet needs. Community collaborative projects, mental health supported housing, and an expansion of veterans' mental health programs and crisis residential services are examples of initiatives that can transform the delivery of behavioral health services in Texas.

- **In-Patient Hospital Services.** DSHS has faced challenges in the past few years regarding capacity and safety in state-operated psychiatric hospitals. The agency has taken steps to ensure that State Hospitals provide quality care, including making changes to the hospital environment and enhancing staff training and supervision. DSHS continues to analyze trends and systemic issues that impact client safety in individual hospitals and to implement corrective action when needed.

  Additionally, State Hospitals have experienced an increased use of resources by the forensic population, which results in a corresponding reduction of beds for civilly committed patients. DSHS has added forensic beds to the State Hospital capacity and contracted through the mental health authorities for civil beds in local hospitals. The additional funding for behavioral health services will provide more intensive service and supports in the community, providing alternatives to civil commitments. DSHS continues to work with judges and courts to follow legislation requiring that patients who are not likely to regain capacity be placed in less restrictive, non-hospital settings.

- **Licensing and Regulatory Services.** Rider 59 (H.B. 1, Article II, DSHS, 82nd Legislature, Regular Session, 2011) provided an opportunity to assess regulatory programs and functions to identify potential efficiencies, cost savings, and revenue increases. As a result of this assessment, DSHS has initiated licensing fee changes where possible and continues to assess its fee-management processes and costs associated with programs that do not charge a fee. DSHS has also invested in enhancements to the Regulatory Automated System and other operational improvements using IT. The Regulatory Services Division has initiated business operation changes to meet the goal of reducing routine inspections and complaint investigations that would have the least impact on public health and safety. DSHS regulatory programs have compiled numerous process improvement methods to gain further efficiency in regulatory operations. As the impact of changes already implemented is evaluated, additional process improvement strategies will be assessed and implemented for maximum impact.

DSHS is large state agency with extensive responsibilities for oversight and implementation of public health and behavioral health services in Texas. The Self-Evaluation Report demonstrates the complexity and array of services administered by staff in Austin and across Texas. The Commissioner and DSHS staff will be pleased to provide any additional information to assist the

Sunset Commission in its review of the agency. Additionally, DSHS looks forward to the opportunity to discuss agency operations with Sunset staff as the process moves forward.

## ATTACHMENTS

### Attachments Relating to Key Functions, Powers, and Duties

1. Agency's enabling statute.
2. Annual reports published by the agency from FY 2008 – 2012.
3. Internal or external newsletters published by the agency from FY 2011 – 2012.
4. List of publications and brochures describing the agency.
5. List of studies that the agency is required to do by legislation or riders.
6. List of legislative or interagency studies relating to the agency that are being performed during the current interim.
7. List of studies from other states, the federal government, or national groups/associations that relate to or affect the agency or agencies with similar duties or functions.

### Attachments Relating to Policymaking Structure

8. Biographical information of all policymaking body members.
9. Agency's most recent rules.

### Attachments Relating to Funding

10. Agency's Legislative Appropriations Request for FY 2014 – 2015.
11. Annual financial reports from FY 2010 – 2012.
12. Operating budgets from FY 2011 – 2013.

### Attachments Relating to Organization

13. Map of regional boundaries, including local and regional public health coverage areas, and map of State Hospital coverage areas.

### Attachments Relating to Agency Performance Evaluation

14. Quarterly performance reports completed by the agency in FY 2010 – 2012.
15. Recent studies on the agency or any of its functions conducted by outside management consultants or academic institutions.
16. Agency's current internal audit plan.
17. Agency's current strategic plan.

## ATTACHMENTS – CONTINUED

18. Internal audit reports from FY 2009 – 2013 completed by or in progress at the agency.
19. List of State Auditor reports from FY 2009 – 2013 that relate to the agency or any of its functions.
20. Customer service surveys conducted by agency in FY 2012.

**Additional Attachments**

21. List of reports required by statute. (Section XI.A).
22. Glossary of acronyms.