INNOVATIONS...

IN HEALTH & HUMAN SERVICES

Report to the 76th Legislature on
Streamlining and Simplifying
Delivery of Services
February, 1999

TEXAS HEALTH & HUMAN SERVICES COMMISSION

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✪ Introduction

The mission of the Health and Human Services Commission is to *provide the leadership and innovation needed to achieve an efficient and effective health and human services system for Texans.*

In support of this mission, the Commission works in partnership with families, communities, and private and public organizations to develop and implement innovative approaches to simplify and streamline delivery of services.

This report, ***Innovations...In Health and Human Services***, summarizes key initiatives undertaken by the Commission. The report is organized into three main sections to reflect areas of major focus, including: *access to services, long-term services and supports, and children's services.* Each section describes separate initiatives and identifies the presenting challenge, the approach taken, the results achieved thus far, and future actions.

This report is submitted to the Governor and Legislature pursuant to Government Code section 531.0243, which requires the Commission to report the agency's efforts to streamline and simplify the delivery of services.

✪ Overall Method

The health and human services enterprise is a complex system of over 200 programs delivered through 11 state agencies with a combined expenditure totaling more than $26 billion for the 1998-99 biennium, or 30 percent of all state appropriations. Since its inception, the Commission has led efforts to test and implement new approaches to streamline and simplify health and human services through development and implementation of specific initiatives to address cross-agency practices.

INNOVATIONS...

IN HEALTH AND HUMAN SERVICES

Innovations... in Health and Human Services

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The overall method used by the Commission includes the following key features:

❶ ***Overarching Approach.*** The Commission is in a unique position to provide an overarching approach to address specific issues or problems that impact multiple agencies. Each health and human services agency has its own mission, goals, priorities, and cultures that can be barriers to change. It is difficult for agencies to transcend these barriers without leadership that guides agencies to operate as an enterprise rather than individual entities. The Commission provides the leadership needed to facilitate and stimulate changes through this overarching approach of focusing on enterprise goals and objectives. This approach reduces fragmentation of individual agency efforts and achieves more effective use of resources.

❷ ***Partnerships.*** In order to accomplish broad-based effective changes, partnerships must be formed with state and local agencies, providers, organizations, and consumers as appropriate. The initiatives pursued by the Commission have all involved partnerships so that stakeholders support and are a part of the change process. Use of partnerships in making system changes precludes unilateral agency actions, which can have a ripple effect across the health and human services enterprise. Partnerships also maximize the likelihood that ensuing changes will better meet the needs of consumers.

❸ ***Local Responsibility.*** The most effective integration of health and human services occurs at the local level. Individual communities are in the best position for determining how to unify and deliver services in a more efficient manner. Many of the Commission initiatives involve partnerships with local communities who have responsibility for implementing new approaches. The Commission plays a critical role by providing technical assistance and support to these local communities. Communities encounter many of the same system complexities experienced at the state level such as multiple and categorical funding streams administered through diverse structures. The Commission provides support to eliminate barriers and remove obstacles so that communities can implement innovative approaches to streamline and simplify services.

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❹ ***Methodical Process.*** The Commission employs a methodical process with each of the initiatives undertaken. In addition to forging partnerships and working with local communities, this methodical process involves a progression of steps. These steps include: studying or analyzing the problems and issues; designing approaches to result in improvements or efficiencies; testing the new approaches on a limited scale before roll-out on a system-wide basis; evaluating the effectiveness of the new approach; and revising the approach as needed based upon evaluation results. The methodical process ultimately produces the most effective results because stakeholders have been integrally involved, problems have been carefully assessed, changes implemented have been evaluated, and need for further improvements have been identified. Such a process results in the "right" problem being addressed and avoids the creation of other problems.

✪ Value of the Initiatives

This report details the directions and accomplishments of a variety of initiatives led by the Commission. Each initiative has resulted in multiple benefits. These benefits are briefly highlighted below and illustrated with examples from specific initiatives.

➡ **Improving access to services.** The *Texas Information and Referral Network* is one of several initiatives addressing access to services. This initiative provides an unprecedented approach to coordinate state and local information about health and human services that people may access either by computer or telephone.

➡ **Integrating and coordinating delivery of services.** The *Community Transportation Services* initiative confirms the benefits of communities locally coordinating services provided by numerous agencies and providers so that all resources — vehicles, people, and funds — can be maximized to better meet the growing needs for transportation.

OTHER RECENT REPORTS AVAILABLE INCLUDE:

- *Texas Medicaid In Perspective*
- *Impact of Medicaid Managed Care on the Public Health Sector, (1998)*
- *Phase II Recommendation of Plan for Children's Health Insurance Program (1998)*
- *A Plan to Increase Access to Health and Human Services Information (1998)*
- *HB2596 Implementation. A Report to the 75th Legislature (1998)*
- *The Value of a Comprehensive Texas Information and Referral Network (1998)*
- *TIES Project: HB2777 Plan (1998)*
- *Community Transportation in Texas (1998)*
- *Development of a Consolidated Community Transportation Rules Database (1998)*
- *Co-Location of Health and Human Services Offices in Texas (1996)*
- *Electronic Availability of Technical Assistance (1998)*
- *An Assessment of the Design and Delivery of Long-Term Services and Supports (1998)*
- *Texas Long-Term Care Plan (1998)*
- *Combining Community-Based Waivers: A Feasibility Study (1998)*
- *Agency Coordination Task Force Report (1998)*
- *Report to the Governor and 75th Legislature on Guardianship Issues (1998)*
- *Permanency Planning for Children in Texas. Report to the Texas Legislature (1998)*
- *Evaluation of the CRCGs of Texas: Phase 1 (1998)*
- *Taking the Time to Make a Difference. Fiscal Year 1997/98 Annual Report*

Innovations...
in Health and Human Services

OVERVIEW

- **Maximizing existing resources.** *Community Resource Coordination Groups* demonstrate how agencies can work together to serve children and youth with needs that can only be addressed by multiple agencies. This statewide initiative provides a mechanism for agencies to come together on an individual case basis to develop service plans to address the complex needs of children and youth with existing resources.

- **Achieving administrative efficiencies.** *Co-Location of Services* is an ongoing effort of the health and human services agencies to co-locate offices when feasible to not only improve access to services for consumers but also to achieve administrative cost-savings through sharing expenses and resources.

- **Utilizing technology to improve efficiency and effectiveness of services.** The *Texas Integrated Enrollment and Services (TIES)* initiative best exemplifies how technology can be used to improve efficiency and effectiveness of services. This is a major undertaking to integrate eligibility determination and enrollment for over 40 health and human services programs by using a single application process supported by advanced technology. Additionally, the *Electronic Technical Assistance* efforts show how health and human services agencies are using the Internet as a forum for efficiently and conveniently exchanging general and technical information with providers and the public.

- **Facilitating state and local partnerships.** The *Children's Financing Initiative* demonstrates how local communities can blend or integrate existing funding for children with severe emotional disturbances. These communities are pooling their resources in innovative ways to better serve children within their own families and communities.

- **Fostering innovation at the state and local levels.** The *Guardianship Alliance of Texas* has developed a plan to increase the capacity of counties to provide guardianships. This initiative has stimulated the expansion of local guardianship programs and creatively maximized state investment of resources.

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- **Analyzing program services and expenditures.** The *Long-Term Services and Supports* initiative has completed the most comprehensive assessment to-date of expenditures and agency programs providing long-term services. This assessment identified inconsistencies in the design and delivery of services. A process is now in place to determine specific improvements and administrative efficiencies that will result in uniform practices across programs.

- **Implementing consistent policies for the health and human services enterprise.** The *Children with Disabilities* initiative illustrates a coordinated approach to implementing a new state policy concerning the importance of families in the lives of children. The health and human services agencies have worked in concert with the Commission to implement permanency planning statewide to decrease the number of out-of-home placements for children with disabilities.

- **Standardizing agency practices.** Both the *Community Transportation Services* initiative and the *Long-Term Services and Supports* initiative focus in particular on achieving cross-agency uniformity with various practices. This includes practices such as rate setting for similar services, common outcome measures and monitoring processes, and standardized reporting of services.

It should be noted that in addition to the initiatives described within this report, the Commission is also implementing other statewide initiatives such as Medicaid Managed Care and the Children's Health Insurance Program which are described in separate reports, *(see text box on page 3 for a list of other reports available)*. Furthermore, individual health and human services agencies are leading other efforts to streamline and simplify the delivery of services. One example is the interagency initiative on Seniors and Substance Abuse led by the Texas Commission on Alcohol and Drug Abuse which is receiving national attention. These efforts will be detailed in the next legislative report on streamlining and simplifying services.

VALUE OF THE INITIATIVES

- Improving access to services
- Integrating and coordinating delivery of services
- Maximizing existing resources
- Achieving administrative efficiencies
- Utilizing technology to improve efficiency and effectiveness
- Facilitating state and local partnerships
- Fostering innovation at the state and local levels
- Analyzing program services and expenditures
- Implementing consistent policies for the health and human services enterprise
- Standardizing agency practices

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✪ Lessons Learned

Implementation of these initiatives has afforded the Commission opportunities to learn valuable lessons concerning efforts to streamline and simplify services for the health and human services enterprise. These "lessons learned" will help guide future efforts so that additional changes in the health and human services enterprise can be made in the most expeditious and effective way possible. These "lessons learned" are briefly summarized below:

- **Time for Change.** The time required to study, plan, implement, and monitor new approaches is usually underestimated by all participants. Most initiatives involve the participation of staff who have existing full-time responsibilities. Involvement in system change initiatives is an added activity that must be balanced with maintaining current operations. Staff must deal with competing pressures of ensuring that consumer needs continue to be met while simultaneously marshaling resources to engineer and implement new approaches. Realistic expectations about the time needed to effect changes must be established early to avoid frustrations during implementation.

- **Communication.** It is critical that staff throughout an agency or organization be knowledgeable about all aspects of the initiative. Full implementation requires involvement of staff up and down the line including policy makers, administrators, and managers, as well as front-line workers. Effective communication about the mission, purpose, and goals, as well as implementation strategies contributes to the initiative's overall success. Failure to communicate may result in actions that inadvertently create obstacles which impede implementation of new initiatives.

- **Transition.** With ever increasing shifts to community-based service delivery structures, it is necessary for state agencies to provide supports and technical assistance to facilitate a successful transition. Communities need assistance to push aside obstacles that stand in the way of innovation. The more successful initiatives involve a strong state-local partnership in which the state role is facilitating rather than directing, helping rather than thwarting, and advocating rather than opposing. Effective partnerships require new skills at the state level in order to strengthen the effectiveness of local efforts.

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- **Consumer Involvement.** People receiving services need to participate in initiatives through their involvement in all aspects of decision making about the design and delivery of services. The voice of consumers shapes an initiative to achieve the highest quality and most relevant service delivery system. Effective service delivery models also strongly involve individuals and families in individualized service planning.

- **Community Uniqueness.** The adage, "one size doesn't fit all", is particularly relevant with communities that participate in initiatives. Community strengths and needs are individualized and dependent upon the population living in the community and the existing service system. Service priorities are best determined at the local level. Flexibility is necessary for local structures to oversee and coordinate planning and the design and delivery of services. Efforts to replicate new approaches must take community differences into account so that methods can be tailored appropriately.

- **Incentives.** Incentives, especially those related to funding and resources, stimulates community initiatives and brings partners to the table to explore and devise methods to improve the efficiency and effectiveness of services. Community initiatives involve difficult and time consuming work — relationships must be formed, time must be carved out of busy days, a common vision must be formed and shared, stakeholders must be willing to change practices, and creative solutions to problems and barriers formulated. Incentives increase the likelihood that communities can muster the resolve to invest time and energy to make changes. It is clear, however, that incentives only get the process started. Initiatives that have been stimulated by the state through special, time-limited funding often do not endure. For initiatives to be sustained over time and after special funding has ended, successful communities have demonstrated a strong commitment and an ability to tap into ongoing or traditional funding streams and blend or integrate these resources.

LESSONS LEARNED

- Build in sufficient *time for change*
- Ensure effective *communication* throughout the organization
- Facilitate a successful *transition*
- *Involve consumers* in all aspects of decision making
- Take each *communities' uniqueness* into account
- Use *incentives* to get the process started
- Balance *accountability* with local flexibility
- Move *beyond coordination*

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- **Accountability.** Addressing the issue of accountability is challenging to partners at the state and local levels. As communities adopt more local responsibilities for the delivery of health and human services, additional accountability for service outcomes must be assumed. New approaches for ensuring accountability while allowing local flexibility must be developed at the state level. Demands to demonstrate the effectiveness of services in terms of outcomes realized for people served are ever increasing. Innovative methods are needed to measure meaningful outcomes and to establish benchmarks to measure progress. The responsiblity for effective stewardship of resources must be jointly shared at the state and local levels.

- **Moving Beyond Coordination.** There is no question that significant gains (such as improving program efficiencies and services by stretching and maximizing resources) can be made through coordination efforts. The need itself to "coordinate", however, relates directly to the complexity and fragmentation of the existing structure of the service system. To move beyond coordination, to realize further benefits and efficiencies, requires re-engineering of service delivery, including funding distribution. It is anticipated that future initiatives may have this focus.

✪ Conclusions

The initiatives described within this report demonstrate a variety of new approaches used by the Commission to streamline and simplify the delivery of services for the health and human services enterprise. Significant improvements have been made in the service delivery system which have been beneficial to consumers and have demonstrated how resources can be used more efficiently and effectively. The experience gained through implementation of these initiatives thus far, strengthens the ability of the Commission to lead future efforts to streamline and simplify services. The Commission will continue to identify opportunities to test new approaches for operating the health and human services enterprise to ensure quality and maximize resources.

"The Commission will continue to identify opportunities to test new approaches for operating the health and human services enterprise to ensure quality and maximize resources."

ACCESS TO SERVICES

- Texas Information and Referral Network
- Texas Integrated Enrollment and Services
- Community Transportation Services
- Co-Location of Services
- Electronic Technical Assistance

THE CHALLENGE

How do I find out about health and human services that I may need? Where do I go? Who do I call?

People in need of some type of health and human services often struggle with a very basic problem of finding out about services in their local community. The difficulty of finding correct information is a frequent complaint of those seeking help.

Communities have services provided directly by state agencies, through county and city departments, and through private organizations such as non-profit entities, volunteer groups, churches, etc. When you consider the range of health and human services that may be available, there literally can be hundreds of different resources depending upon the size of the community.

Obtaining information about resources can be overwhelming. For many people the process begins with a phone call to an agency. This often results in the person getting more phone numbers to call. While the hunt for information has begun, it may or may not be successful.

The frustrating search for information may result in the person not getting the right information so that their needs continue to go unaddressed. Problems may worsen and ultimately may require more costly services or interventions.

Staff working in health and human service programs often experience the same type of frustration in finding information about resources. People receiving services often have complex needs that can not be addressed through a single program. Thus, staff must search for other needed resources for people involved in their programs.

Health and human service programs can be quite dynamic with frequent changes in case loads, program availability, and eligibility requirements. Keeping up with all that information poses many challenges to professionals and consumers.

Described below are some **CASES IN POINT.....**

❖ *Jane is a teenager, 16 years old, who is pregnant. Jane speaks only Spanish, is unmarried, and has a 3rd grade education. She has no permanent place to live and is not attending school. In addition to needing a safe place to live, she needs prenatal care, childbirth classes, and continuing education. Jane asks for help at her church. The church minister finds her a family to stay with but doesn't know who to call about the other services that she needs.*

TEXAS INFORMATION & REFERRAL NETWORK

Texas Information & Referral Network

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Reports available include:

A Plan to Increase Access to Health and Human Services Information (1998)

The Value of a Comprehensive Texas Information & Referral Network (1998)

HB 2596 Implementation, A Report to the 75th Texas Legislature (1998)

THE CHALLENGE

✣ *Mrs. Wright has been missing work to care for her husband who just recently had heart surgery and is not working. She and her husband have health insurance which has paid for the medical bills. Mrs. Wright needs help to pay the rent and utility bills for the next few months until she can work full-time again. She calls about a program that provides rent assistance but learns that the allocation of funds have already been used up for that month.*

✣ *Mr. Simone is 20 years old and married with two toddlers. He and his family can no longer live with relatives and must move out within a few days. He starts a new job today and his wife plans to work the opposite shift so they can share child care responsibilities. They need to find a place to live and Mrs. Simone needs help finding a job. Mr. Simone learned from the emergency shelter that he may qualify for subsidized housing but there is a waiting list.*

✣ *Ms. Brown is a single mother who has been unable to work due to injuries from a car accident. Her teenage son has had emotional problems as a result of the accident. They have no income and she continues to need home health care to recover from her injuries.*

Ms. Brown looks through the phone book but isn't sure who to call. She calls one local agency and is given the phone numbers of some other agencies that may be able to assist her. From one agency she learns that she is not eligible for services, and from the other she learns they have no services to meet her needs.

Who can these people turn to for help?

As the above examples illustrate, people often have difficulty getting connected to services they need.

An additional problem relates to the 55 toll-free telephone numbers that are operated by state agencies for information and referral concerning specific programs.

Overall, this system has developed in a piecemeal fashion without overall coordination of resources and services. Agencies have purchased and developed duplicate equipment and information systems. Information provided by one program is not linked to other programs. Operators are often unaware of services available through other agencies, particularly those provided by local organizations.

Even though these toll-free numbers respond to approximately 684,000 calls a year, consumers still may not receive the information needed.

THE APPROACH

What is happening to address this problem?

Texas Information and Referral Network.
The *Texas Information and Referral (I & R) Network,* initially established in 1991, is a partnership between various public and private information and referral providers, agencies, and organizations. The Texas Planning Council for Developmental Disabilities has supported this work through grants to the Commission.

Legislation directed the Commission to develop, coordinate, and implement the network.

The purpose of this Network is to create a statewide system for information and referral so that people have one source for obtaining accurate information about programs and services in a timely and efficient manner.

Information and Referral Task Force.
An Information and Referral Task Force guides the efforts of this initiative. Work of the Task Force is coordinated by the Commission. The Task Force studied the problem and subsequently designed a model and plan for a comprehensive statewide network for information and referral. This is described in detail in the report, *A Plan To Increase Access to Health and Human Services Information (1998).*

Community Information Centers.
A major component of the Network is the designation of Community Information Centers (CICs). These CICs serve as the "first point of contact" within local communities. The CIC compiles and maintains accurate information about programs, services, and resources available from all providers within their community. This means that consumers and professionals can literally call one phone number in their community and receive all the information to get connected with services they need.

Many of the Community Information Centers maintain and update detailed information about resources through computer systems. Automation makes it easier not only to locate and retrieve information but also to collect and store information about overall needs for services within a community. The automated system can also provide information helpful in planning efforts to address gaps in services and unmet needs.

Through funds ($75,000) provided by the Texas Workforce Commission in 1997, the Information and Referral Network provided grants to 28 local Community Information Centers to improve technology and telecommunication systems. Computers, modems, and telephone lines were added and upgraded.

Partners in the Texas Information and Referral Network:

- Local community information and referral providers
- State agency information and referral providers
- State health and human services agencies
- United Way agencies
- Texas Planning Council for Developmental Disabilities
- Texas Workforce Commission
- Texas Alliance of Information and Referral Services
- County Judge's Offices
- Church ministry programs
- Community Councils

Texas Information & Referral Network

Related Legislation in the Government Code:

Section 531.0312 - Statewide Information and Referral Network: directs the Commission to develop, coordinate, and implement a statewide information and referral network.

Section 531.0313 - Electronic Access: establishes that the Network may develop an Internet site to provide information about health and human services provided through public and private entities.

Section 531.0314 - Information and Referral System Task Force: directs the Commission to establish a Task Force to implement the statewide system and make recommendations to the 75th Legislature by December, 1998.

THE APPROACH

Area Information Centers. In addition to the Community Information Centers, creation of regional Area Information Centers will form another important component of this statewide system. The Area Information Centers will coordinate with the Community Information Centers and disseminate information for their region.

Automation. Another component of the Network design is the use of automation to connect current information and referral providers and to make information available through the Internet.

Through use of a central web site, professionals and consumers will be able to obtain needed information about resources in a local community. Area Information Centers will create regional databases of information about resources which will be linked through this web site. The web site will provide information about services in communities throughout the state.

Call "211". Like the "911" phone number used for emergencies, a single phone number to call for community resource information is envisioned.

Regardless of where a person lives, a call to "211" will allow a consumer to get information about services. The call will be answered by an information and referral specialist in their community who has access to the regional database of information. Having such a single number would eliminate the current problems of not knowing where to turn to get information quickly.

An alternative to "211" that is proposed is the use of a statewide "1-800" number, which would serve similar purposes but is less desirable because it will not be as easily recognizable and known.

Thus, the overall plan for the statewide information and referral network is to provide a coordinated and comprehensive system through which people may access needed information either by computer or telephone.

THE RESULTS

How has this made a difference?

Single Point of Contact. Currently, there are 103 Community Information Centers serving 140 counties comprising approximately 90% of the Texas population. Now, consumers and professionals alike can access information through this "single point of contact."

Operators of these Information Centers are varied and include United Way programs, County Judge's Offices, hospitals, state agencies, and a myriad of local agencies.

Publications. To assist the Community Information Centers, the Commission periodically publishes the *Health and Human Services Reference Guide* which contains descriptive information about each type of program provided by the eleven health and human services state agencies. In addition, the Commission publishes *Finding Help in Texas* which is a directory of information and referral providers throughout the state. This directory is used weekly or monthly by approximately 67% of the people who have this resource.

Definitions & Standards. To help share information in a consistent manner, the Task Force adopted common descriptions and definitions of health and human services which are used by the Community Information Centers. By using common terminology, communication is greatly improved and standardized data can be collected.

National standards for providing information and referral services have also been adopted and are being implemented by information and referral providers. This helps ensure that the information and referral services are of high quality and that there is consistency throughout the system.

Pilot Phase. Twenty-five geographic regions in Texas are identified, each of which will be served by an Area Information Center. Each center will serve a cluster of counties. Most of the 25 Area Information Centers have been identified. Eight of the Area Information Centers will begin work during an initial pilot phase in 1999. These eight centers have already begun to develop local partnerships with agencies in their areas and to make the transition to using the national standards and common definitions and descriptions of services.

How many calls are made to the network each year?

About one million.

What kind of information do callers request?

Information about:

- Housing
- Job Placement Assistance
- Education Opportunities
- Transportation
- Food
- Health Care
- Financial Assistance Programs
- Clothing
- Mental Health Services

Special services for:

- Elderly
- Children, youth, and families
- Persons with disabilities or medical conditions
- Homeless
- Victims of domestic violence

Texas Information & Referral Network

CHECKLIST OF ACCOMPLISHMENTS

- ✔ Helping consumers get connected to services
- ✔ Improved coordination of community resource information
- ✔ Increased awareness of available local resources
- ✔ 104 Community Information Centers operating as "single point of contact"
- ✔ 25 Area Information Centers defined
- ✔ A "blue print" or conceptual design to guide development of the Network
- ✔ *Health and Human Services Reference Guide*
- ✔ *Finding Help in Texas: A Directory of Information and Referral Providers*
- ✔ Common descriptions and definitions of health and human services
- ✔ National standards for information and referral providers implemented
- ✔ Petitioned the FCC to designate "211" as national telephone number
- ✔ Roles, responsibilities, and standards for the Network defined
- ✔ Partnerships developed to provide training and technical assistance

THE RESULTS

Internet Access. A web site for the *Texas Information and Referral Network* (at *www.hhsc.state.tx.us/tirn/tirnhome.htm)* is operational and contains information about the initiative and lists the Community Information Centers. The *Health and Human Service Reference Guide* and *Finding Help in Texas* are also included at this site.

Resources. Other resources for Community Information Centers includes a technical assistance publication called *The Exchange* and an Internet mailing list, *IR-Networker*, for information and referral providers in Texas, the United States, and international sites. During 1998, regional training conferences were held for over 1,000 state and local information and referral providers.

Petition for "211". A petition was submitted in May, 1998, to the Federal Communications Commission (FCC) to designate "211" as the single telephone number for community resource information nationwide. The FCC completed a comment and reply process and continues to consider the petition.

Additionally, the Commission is working with the Texas Public Utilities Commission (PUC) to assign the "211" dialing code to the *Texas Information and Referral Network* for access to community resource information in Texas. A decision by the PUC is pending.

Statutory Recommendations. As required by the 75th Legislature, the Information and Referral Taskforce recommended statutory changes for consideration to further implementation of the statewide network. The recommendations are for the Legislature to:

1. Authorize implementation of a "211" dialing code for use by the public to access information and referrals concerning community service organizations.

2. Require any health and human services organization receiving state funds to provide the *Texas Information and Referral Network* with information about services provided and to update such information quarterly. The information would be included in the statewide information and referral network.

WHERE DO WE GO FROM HERE?

☆ ***This unique public-private partnership*** will continue to strengthen. Community Information Centers will continue to improve services to their local communities by using the common definitions and descriptions of health and human services and participating in the national accreditation program.

☆ ***To support the current work of the Community Information Centers***, and to develop the automated component of the Network as envisioned by the Task Force, the Commission has included in the FY 2000-2001 Legislative Appropriations Request (LAR), funds for continued operation of the *Texas Information and Referral Network*. Grant funds from the Texas Planning Council for Developmental Disabilities will no longer be available after FY1999 to support this initiative. Funds requested in the LAR (approximately $500,000) would be used to develop and maintain the automated information and referral system.

☆ ***Area Information Centers will be phased in***, assuming LAR funding. During FY2000, eight centers will be operational with the remaining phased in over two subsequent years. The automated system for the Network will be fully operational by 2002.

☆ ***To make the "call 211" system*** (or an alternative single phone number) a reality, significant investment of funds will be necessary to support the telecommunication costs and the staff requirements to operate such a system. The likelihood of this will be dependent on legislative interest, further development of the public-private partnership guiding this initiative, and creative alternatives for funding.

☆ ***The Texas Information and Referral Network has developed the blue print*** for an overall statewide network to benefit both consumers and professionals by providing a well-publicized, coordinated system to access information about services and programs that people need. Few states have such a vision but Texas is ready to take the next step in creating a comprehensive system to meet the needs of consumers for information.

TO-DO LIST

- Funding for further development of the automation part of the Network
- Funding for the "call 211" or single phone number system
- Implementation of Area Information Centers
- Continued support of Community Information Centers
- Strengthened public - private partnership
- Definition of telecommunications requirements

THE CHALLENGE

Why do I have to give same information over and over to find out if I qualify to get help from different programs?

The steps that people go through to apply and enroll in health and human services programs are cumbersome, time-consuming, and duplicative. Typically, people make several office visits to meet in person with agency workers who collect the necessary information to begin the process to access services.

The information collected usually includes basic personal and family related information as well as financial and resource data. Often, this information has to be verified through source documents like birth certificates. Once the needed information is collected, a decision can then be made considering whether or not the person is eligible to receive the requested service. Overall, these steps take a lot of time — time for people applying, and time for workers to collect and process the information.

To add further frustration, to apply for different programs, people may have to go to multiple offices and often provide the same information more than one time. Even though the information may be identical, the application forms used by programs are different. Additionally, some programs determine eligibility and process enrollment separately despite the fact there may be overlap in populations served and services provided.

When a person seeking services begins the process, the needs of the entire family are not necessarily considered and addressed. The existing application process used by many agencies is focused on an *individual* and a single problem rather than an *entire family*. Consequently, further duplication is built into the process because people applying for services for more than one family member have to once again provide basic information repeatedly to different agency workers.

The program a person first enrolls in may not be the best and most cost-efficient one to meet the person's needs. Currently, there is not a comprehensive screening system in place for workers to assess the appropriateness of other programs. This lack of comprehensive screening also contributes to the frustration that many consumers may experience as well as delays in receiving services.

Thus, the application and enrollment process is often confusing and frustrating for consumers. Agency office hours often require people seeking services to take time away from work. Needs for transportation and child care just to apply for services may be problematic for consumers.

TEXAS INTEGRATED ENROLLMENT AND SERVICES

Texas Integrated Enrollment and Services

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Reports available include:

TIES Project House Bill 2777 Plan, (1998)

TIES Project Final Report and Recommendations (1998)

THE CHALLENGE

How much money is spent enrolling people in services? It is estimated that Texas spends over **$500** million annually to process applications and determine eligibility for more than 40 programs. Unfortunately, the complexity of the existing process used to apply for and access services results in increased administrative costs for agencies. Repeated visits, redundant information collection, and lack of screening requires time for workers already stretched to fulfill their responsibilities.

Why is this process so difficult? One reason is the fact that programs are administered by multiple state and local agencies without a cross-agency effort to coordinate, streamline, and simplify the process.

Other reasons include incompatible and outdated computer systems and federal restrictions. Technological solutions to information sharing have not been widely implemented. Existing federal confidentiality rules place restrictions on sharing information across programs.

THE APPROACH

What is happening to address this problem?

Texas Integrated Enrollment and Services (TIES). Since 1997, Texas has been working in earnest to integrate the separate enrollment and eligibility processes across agencies for health, human services, and workforce programs.

The *TIES* initiative is a major undertaking to completely re-engineer the multiple processes and structures currently used by agencies to enroll people in programs. The overall vision is to create a single process, used across agencies and programs, for determining eligibility and enrolling people for services in a timely, efficient, and non-duplicative fashion.

The goals of the *TIES* initiative are to:

1. Improve client access and quality of services;
2. Promote personal responsibility and move clients from welfare to work;
3. Produce long and short term savings and minimize dependence on government; and
4. Continuously improve performance related to defined standards.

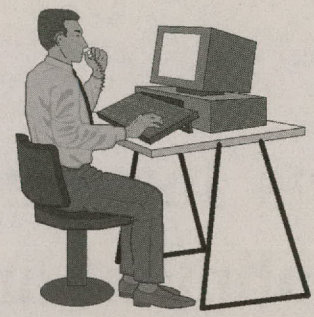
The 75th Legislature established legislation in 1997 that set forth new requirements for this initiative.

These requirements include the following:

- ➔ Integrating the welfare-to-work process consistent with state and federal welfare reform;
- ➔ Prioritizing the design of a technology system to support a re-engineered process;
- ➔ Conducting public hearings to obtain input into the *TIES* process;
- ➔ Requiring state agencies to work together rather than compete; and
- ➔ Monitoring by a newly created Legislative Oversight Committee.

TIES Project Team. The Commission is the lead statutory agency for this initiative and a full-time interagency project team is in place to implement the *TIES* legislation. The Texas Department of Human Services has taken the lead in managing the project. Staff from the Texas Department of Human Services, Texas Department of Health, and Texas Workforce Commission comprise the project team. Electronic Data Systems assists the project team with re-engineering and other planning tasks.

The project team is responsible for the re-engineering effort, and developing the required legislative plan, federal approval documents, and the bid documents for the new automation system.



EXAMPLES OF PROGRAMS INVOLVED WITH *TIES*

Texas Department of Human Services:

- Food Stamps
- Temporary Assistance to Needy Families (TANF)
- TANF Related Medicaid
- Medicaid Waivers
- Nursing Facility Care
- Primary Home Care
- Client Managed Attendant Services

Texas Department of Health:

- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Chronically Ill and Disabled Children (CIDC)
- Medically Dependent Children Program (MDCP)
- Medical Transportation
- Texas Health Steps (EPSDT)
- Immunizations

Texas Workforce Commission:

- Food Stamp Employment and Training
- Temporary Assistance to Needy Families CHOICE
- Job Training Partnership Act (JTPA)
- Employment Services
- Child Care

Texas Integrated Enrollment and Services

Related Legislation in the Government Code:

Section 531.044 (Historical and Statutory Note section 9.12) - Integrated Eligibility Determination: directs the Commission to develop and implement a plan for the integration of services and functions relating to eligibility determination and service delivery by health and human services agencies, the Texas Workforce Commission, and other agencies.

Section 531.202 - 531.204 Legislative Oversight Committee: Establishes an oversight committee for *TIES*; specifies membership of the committee; outlines powers and duties; requires an annual legislative report on the status of the effectiveness of *TIES*, including recommendations.

THE APPROACH

Identifying Agency Programs. The first step in getting started with *TIES* was to identify the agency programs to include. Definitions and criteria were developed and applied to programs within the Texas Department of Human Services, Texas Department of Health, and the Texas Workforce Commission. The criteria included assessing whether the program: requires financial eligibility determination; serves a common population; provides the same benefits to different populations; has potential to eliminate duplicate services; and provides opportunity for cost savings. *(See the text box on page 18 for a list of some of the programs involved with TIES.)*

Business Process Re-Engineering. The next major step was to conceptualize a model for doing business in a new way. Legislation requires that "*business process re-engineering*" be used as the methodology for developing the new model for eligibility processes for *TIES* programs. This innovative methodology is highly structured to stimulate a fundamental "re-thinking" and radical redesign of a business process, from a customer perspective, to achieve dramatic improvements. In this case, a new model for streamlining and simplifying enrollment was developed along with identifying the people and technology needed to support it.

Program Involvement in TIES. After the new business model was developed, extensive cost analyses determined that some programs did not offer a high opportunity for cost savings and would, in fact, incur additional costs as a result of having *TIES* determine eligibility.

As a result, the level of involvement with *TIES* was determined for 48 programs. Thirty of the programs, considered "core" programs, will have ***full involvement*** with *TIES*, meaning that *TIES* will be fully utilized for eligibility determination and enrollment. This includes the larger programs such as Food Stamps, Medicaid, Temporary Assistance to Needy Families (TANF), Long-Term Care, and the Supplemental Nutrition Program for Women, Infants, and Children (WIC).

There are six programs that will have ***adjunctive eligibility*** determined, meaning that once eligibility is established for a "core" program, the person is automatically eligible for these other programs. The remaining programs will be involved with *TIES* by either sharing data back and forth or making inquiries into the *TIES* system to see if a person has been certified eligible for Medicaid. The structure of *TIES* will be flexible to add new programs like the Children's Health Insurance Program.

THE RESULTS

How has this made a difference?

Re-engineered Model for Eligibility and Enrollment. Texas has developed an innovative model for integrated eligibility and enrollment that both improves access to services and saves the state significant dollars when fully implemented.

A key conclusion from the business process analysis is that the new model should accommodate a person accessing multiple programs through a single application process. This approach enables a person to be screened, and to provide information and produce verification documents only one time for any combination of the "core" programs needed.

Though many programs collect the same information and carry out similar activities, the order of events is often different depending on the program. Thus, the new model could not assume a uniform flow of activities across programs. Instead, the model consists of 22 flexible computer-based modules which can be automatically sequenced as needed depending on the programs that are requested.

For example, there are modules to calculate benefits, to collect information for an application, to screen for other services, to make referrals through the *Texas Information and Referral Network*, to track services, etc. The sequence of the modules that staff work through will depend on the combination of services being requested.

A major feature of the new model is that *TIES* will primarily rely on **telephones** to conduct a majority of the steps in the process. It is estimated that over 80% of applications, changes, and other transactions will be conducted by phone using customer service staff as well as a sophisticated automated voice response system.

This feature alone significantly streamlines and simplifies the eligibility determination process. It will be convenient for people accessing services since fewer trips to agency offices will be required and it provides more efficient use of staff, yielding cost savings. Walk-in offices will be available to access *TIES* services as well in the event that a person is unable or prefers not to use a phone.

Key Features of the New Model. In addition to reducing the number of office visits, other characteristics of the new model which improves customer service and cost effectiveness include the following:

- **Streamlined application process** because information is provided only once

KEY FEATURES OF THE *TIES* MODEL

- Multiple ways to access
- Streamlined application process
- Less paperwork
- Face-to-face meeting time reserved for critical functions
- Improved process for welfare-to-work
- Shift in focus to meet needs of the whole family
- Enhanced fraud prevention
- Greater efficiencies
- Better management and planning information

Texas Integrated Enrollment and Services

CHECKLIST OF ACCOMPLISHMENTS

- ✔ Business process re-engineering completed
- ✔ Programs to include and level of involvement in *TIES* identified
- ✔ New model for eligibility and enrollment designed
- ✔ Benchmarking analysis completed
- ✔ Preliminary performance measures drafted
- ✔ Pre-implementation and implementation activities defined and scheduled
- ✔ Cost-benefit analysis performed
- ✔ Impacts of the model identified
- ✔ Need for legislative actions determined
- ✔ House Bill 2777 Plan submitted

THE RESULTS

even when applying for multiple programs (or applying for additional programs at a later time). This information will be stored in the *TIES* database.

- **Less paperwork** through accepting applications by phone or a single application mailed to a "mail center" along with required verification documents.

- **Face-to-face time is reserved for critical functions** staff need to perform such as verification of identify, provision of program education, and completion of functional assessments.

- **Improved process for welfare-to-work** through better automated system interface between *TIES* and workforce development boards to share information.

- **Shift in focus to meet needs of the whole family** through initial comprehensive screening as well as referral through the *Texas Information and Referral Network.*

- **Greater efficiencies** achieved by using an automated mechanism to select the most appropriate source of funding for a specific program or service; changes in policy and law can be easily programmed.

- **Enhanced fraud prevention** through use of risk profiles and identification of overpayment and underpayment of benefits.

- **Better management and planning information** through a single database with an unduplicated count of people receiving services.

Organizational Support for the New Model. The proposed workforce to support implementation of the new model consists of thirteen new job categories for state employees, to be filled to the extent possible from the current state workforce. The Texas Department of Human Services is recommended to be the single entity responsible for management and operation of the *TIES* process and automated system. The agency that has statutory responsibility for each of the *TIES* programs will continue to have rule-making and policy authority.

Technological Support for the New Model. The technology needed for the automated system to support the model will meet industry standards and build upon existing state infrastructure investments.

THE RESULTS

The *TIES* system will have over 216 interfaces with other systems and will utilize existing computer networks. Key technology features include the automated voice response system; high speed printing, scanning, and "intelligent bundling" to support the mail center; a rules-based system to centralize and manage the large set of program rules that underlie *TIES*; and a sophisticated information system to facilitate accurate reporting and effective decision-making.

It is anticipated that this new automated system will replace 75-85% of the functionality of the current automation system used by the Texas Department of Human Services (System for Application Verification Eligibility Referrals and Reporting [SAVERR]).

Measures of Success. Measures to evaluate performance and assess overall effectiveness of the new model have been drafted with input from advocate group representatives. Examples of performance measures include: effective referral to employment and other services, timeliness of application processing, and average cost per eligibility determination. These measures will be further defined to include numerical standards.

Cost-Benefit Analysis. A quantitative analysis was conducted to determine the costs and savings associated with the new model. The *TIES* model will be implemented over a period of several years in which substantial initial investment in the development and installation of technology results in increased costs. Over time, this investment is paid off as process improvements yield lower operating costs.

Based on agencies' FY98 Operating Budgets, the cost-benefit analysis produced the following business case for proceeding with *TIES*:

- $ Estimated savings from the **reduction of 2,539 state employee** positions, from 11,807 to 9,268 will total **$560** million through FY 2007.
- $ Estimated costs primarily for technology development, implementation, and operation through the same time period of FY 2007 will total **$460 million**.
- $ Net savings, when annual savings exceed annual costs, begin in FY 2002 at a total of **$4.8 million**.
- $ Net savings will accrue at **$56 million annually** beginning in FY 2007 following full bond repayment.

What are the qualitative benefits of implementing TIES?

- Faster service access
- Quick, accurate, and comprehensive referrals
- Reduced verification burden
- Better service tracking
- More accurate and consistent benefit calculation
- Streamlined program informing and education
- Improvement in management information and decision support

Texas Integrated Enrollment and Services

WHERE DO WE GO FROM HERE?

☆ ***Pre-implementation activities*** will occur during fiscal year 1999 and culminate in a major contract award for detailed design, development, and implementation of *TIES*. Key documents will be finalized and submitted for approval at both the state and federal levels. Federal approval is needed to receive federal funding support for *TIES.*

☆ ***System development and statewide implementation*** of *TIES* is planned in three stages over a five year period, ending in 2004. While the majority of the design work is completed in *Stage 1*, various modules will be developed and subsets of programs added during the other stages. In each stage, urban and rural pilot testing will be completed prior to statewide implementation.

☆ ***Location for TIES facilities*** will be selected with community and agency input and any needed office build out will be completed during *Stage 1* of *TIES* implementation. The following types of facilities are needed:

- ***Call Centers*** to handle all *TIES* business processes that can be handled via phone.
- ***Mail Center*** to process incoming and outgoing correspondence.
- ***Walk-in Offices*** where a person may complete one or more of the *TIES* activities and/or access services. Preferably, these facilities will be co-located with other service providers. Current eligibility offices may become walk-in facilities depending on decisions made about specific numbers and locations of these facilities.

☆ ***Key issues that may have significant impact*** on the State as *TIES* is implemented will need to be addressed.

☑ *Call Center Location:* It is recommended that the call centers for *TIES* be located in the ten largest metropolitan areas. This recommendation is based on the best economic or business case, but has negative impacts on staff in rural areas and mid-sized cities.

☑ *Federal Waivers:* Several waivers will be needed to implement *TIES*. For example, waivers are needed concerning when signed applications are obtained and for eliminating the requirement that face-to-face interviews must be held even for denied applications. Waiver requests to the appropriate federal entities will be made as needed.

☑ *Federal Approval:* Key documents such as the Implementation Advanced Planning

WHERE DO WE GO FROM HERE?

Document and the Request for Offers must go through a federal approval process. Working with the federal agencies to obtain timely approval will be necessary to meet projected timelines.

☑ *Reductions in Staff*: The plan estimates that 2,539 staff positions will be reduced as a result of efficiencies achieved through *TIES* in combination with the location of call centers. This will cause the state to lose some of its more experienced staff. Legislative proposals are being developed to lessen this impact.

☑ *Integrate and Simplify Rules:* It is critical that efforts to integrate and simplify rules for *TIES* programs succeed to realize cost savings and benefits of *TIES*. Without such simplification, it will be difficult to make programming changes quickly in response to changes in federal and state rules. A systematic process for accomplishing this is underway, but continued interagency cooperation is essential.

☆ ***Legislative actions*** by the 76th Legislature will be requested by the Legislative Oversight Committee. These requests will include:

- *Four Appropriations Riders:* Requests will be submitted for riders to provide the needed budget flexibility to spend, transfer, and carryover funds as needed due to the complexity and uncertainty of timelines associated with *TIES*. A fifth item proposes language for the Appropriations Bill that allows options besides bonds for financing *TIES*.

- *Temporary Retirement Options*: For employees impacted by *TIES*, options to add time and service to enable early retirement will be requested. Also, retention incentives will be proposed to keep key employees on board until they are no longer needed.

- *Statutory Changes*: Changes to state law that would remove competitive procurement rules to allow *TIES* staff to co-locate with private contractors (like workforce boards) will be requested.

TO-DO LIST

- ✪ Submit the Implementation Advanced Planning Document to secure federal funding support
- ✪ Submit for review by federal partners the Request For Offers to acquire technical services and quality assurance
- ✪ Finalize a Risk Management and Project Development Plan for Texas Department of Information Resources
- ✪ Establish specific criteria for determining type, size, and location of facilities
- ✪ Submit federal waiver requests as needed
- ✪ Continue work on integrating and simplifying program rules
- ✪ Further refine performance measures
- ✪ Finalize and submit Legislative Packet

THE CHALLENGE

How can I find a job, take the kids to day care and the doctor if I don't have a car? How can I get out and about if I'm too old to drive my car? How do I get my dialysis treatments if I am too sick to drive?

Being able to get to work, go to job training, access health care services, take children to day care and school, buy groceries, go to church.....to be an active part of the community depends to a great extent on transportation.

For millions of Texans, having a car is as basic as having a place to live. Yet, there are many people who do not have the means to drive or are unable to drive. Indeed, many of the people most in need of health and human services often must face the problem of how to get such a service without some form of transportation.

How many people need community transportation? Based upon a national formula, it is estimated there are almost 6 million people, or 31% of all adult Texans who do not own or can not operate a personal vehicle and must depend on other forms of transportation.

Who are these people? For the most part, they fall into three groups — people who are elderly, people who are poor, and people with disabilities. Unfortunately, this represents people who may be the most vulnerable and have the greatest risks.

Of note is the fact that as the "baby boomer" population ages, there will be additional increases in the elderly group. The number of persons with disabilities is also expected to increase dramatically as medical technology continues to advance. By the year 2020, it is estimated that there will be almost 9.5 million Texans in need of community transportation.

It is clear that needs for transportation will continue to outpace funding.

Who provides transportation? Presently, people use a variety of public and private options for community transportation. In addition to local bus systems, other examples include services provided by community action and senior citizen organizations, American Red Cross, Head Start programs, county hospitals, YMCAs, and private taxi companies.

COMMUNITY TRANSPORTATION SERVICES

Community Transportation Services

For information, contact:

Director of Office of Community Transportation Services

Health and Human Services Commission
P.O. Box 13247
Austin, TX 78711-3247

(512) 424-6581
Fax (512) 424-6590
www.hhsc.state.tx.us/octs/home.htm

Reports available include:

Community Transportation in Texas Report (1998)

Development of a Consolidated Community Transportation Rules Database (1998)

THE CHALLENGE

All together, transportation is provided through *43 separate programs* from 19 state and federal agencies, involving hundreds of local organizations. Considering local, state, and federal resources, funding for community transportation in Texas has exceeded *$1.6 billion a year.*

Despite this tremendous expenditure of dollars, many people go without needed or desired transportation services. The number of different transportation programs creates a complex system.

Many different state and federal agencies sponsor individual programs that provide transportation directly or reimburse transportation costs. Some agencies purchase transportation services from each other, or from public and private systems. Programs have different rules, definitions, rate setting methods, and evaluation strategies.

Finding information about transportation is often difficult *(see discussion of the Texas Information and Referral Network on page 9.)* The availability of such information varies widely at the local level, particularly in rural areas.

A person or family may need multiple health and human services. Transportation for each program may be provided separately. Without coordination among these programs at the local level, services can be costly, fragmented, and ineffective.

Here is a **CASE IN POINT**....

Somewhere in Texas is a family like the Smiths. *Mom, a nursing aide, works the late shift at the hospital. Dad, who was laid off from his job last year, is in training for a job at a new factory. Two Smith children are in public school and the youngest attends a Head Start program. The Smith grandparents also live with the family.*

The Smiths have only one car. Mom drives to work and Dad takes the bus to classes at the Community College. The older kids take the school bus and there is a Head Start bus for the youngest. Granny and Pop don't drive anymore. Granny takes a cab to doctor visits, but since Pop uses a wheelchair he needs the van service with a wheelchair lift. Whenever Granny and Pop are up to the trip, there is also a van to the local Senior Citizens Center.

Six transportation providers assist the Smiths. Even though their buses might follow each other through town, each Smith must ride his or her own bus. Each of these providers are separate programs operating their own vehicles independently.

THE APPROACH

What is happening to address this problem?

Office of Community Transportation Services. Created by legislation in 1991, this Office at the Commission is responsible for coordinating transportation to improve services for people receiving health and human services. A number of approaches have been taken to provide forums for identifying ways to improve services.

Agency Transportation Coordinating Council. Given the many number of transportation programs provided by state agencies, it is critical that there be a mechanism for examining how to bring these programs together.

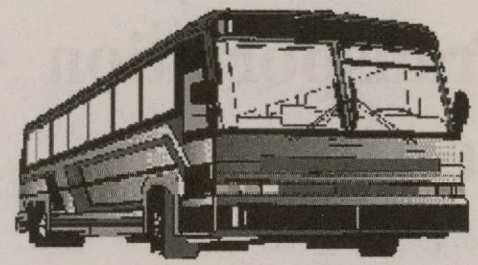
Established in 1994, an Agency Transportation Coordinating Council, consisting of representatives from eleven state agencies, has developed a common vision and action steps to coordinate transportation services across programs.

Community Transportation Collaborate and Forum. Recognizing the need to expand the partnership to include consumers, advocates, and local transportation providers, a Community Transportation Collaborate was created in 1997. This Collaborate and Forum provides input into the overall efforts at the state level to maximize and coordinate funding and services.

Service and Expenditure Information. An ongoing mandate of this Office is to collect information on transportation needs, services, and expenditures for all of the health and human service programs. This provides a basis for identifying steps to take to better coordinate and maximize resources for transportation. Information is shared at the state and local levels to assist in coordination efforts.

Analyzing Rules. Often it can be difficult to coordinate services because the rules and policies by which each program operates may create conflicts or barriers which block change. To remove barriers to coordination, the Office examines rules and policies to identify needed changes.

Demonstrating Coordination. Through grant funds provided to the Commission in 1995 by the Texas Planning Council for Developmental Disabilities, five local



Partners in the Community Transportation Initiative:

- Health and Human Services State Agencies
- Texas Department of Transportation
- Texas Workforce Commission
- Texas Education Agency
- Texas Planning Council for Developmental Disabilities
- Texas Transit Association
- Association for Coordinated Transportation
- Center for Public Policy Priorities
- Disability Policy Consortium
- Federal Coordinating Council on Human Services Transportation
- Private and public transportation programs and providers
- Persons and organizations representing consumers of community transportation

Community Transportation Services

Related Legislation in the Human Resources Code:

Section 131.002 - Establishes the Office of Community Transportation Services in the Health and Human Services Commission. Requires the Office to collect data, create a statewide plan, establish standards, and assist in coordinating resources.

Related Legislation in the Transportation Code:

Section 455.0015 - Directs the Texas Department of Transportation (TxDOT) to include transportation needs of clients of health and human service agencies in planning and funding activities.

Section 459.002 - Requires social service providers to coordinate with each local transportation provider.

Section 459.003 - Requires TxDOT to provide a list of transportation providers to agencies providing social services who shall in turn provide an inventory of current contracts to area transportation providers.

Act of 5/29/97, 75th Legislature, Regular Session - House Concurrent Resolution No. 79:

Resolved that the 75th Legislature officially expresses its support of the transportation pilot projects and encourages the Commission, TxDOT, and the Agency Transportation Coordinating Council to further efforts to maximize and coordinate funding and services. The results of the pilot programs should be reported to the 76th Legislature.

THE APPROACH

transportation coordination models have been implemented. These models provide examples of how local communities can work together to combine transportation resources (vehicles, people, and funds) resulting in improved services.

Recognizing that the size, culture and geographic location of communities pose different challenges, the communities represent a mix of sites — metropolitan, urban/rural, rural, and border sites.

The communities and lead agencies implementing the coordination models include:

- Harris County - American Red Cross;
- El Paso County - LULAC Project Amistad;
- Denton County - SPAN, Inc.;
- Galveston & Brazoria Counties - Gulf Coast Center;
- Bastrop County - Advocacy Outreach

These communities are addressing problems relating to duplication of services; using computer networks to share information related to schedules and routes; and exploring ways to leverage funds through joint bulk purchasing.

In addition to these five communities, other communities have requested assistance in addressing transportation coordination. These communities are building community-wide transportation services through combining resources from the individual programs. The Office assists staff from federal, state, and local agencies in working together by providing information and resolving issues.

The combined efforts of all of these sites provide information on what is feasible and effective within a variety of communities. The resulting information facilitates better planning for coordination of transportation in diverse environments.

THE RESULTS

How has this made a difference?

Defining the Problem. For the first time, specific data about transportation needs, including unmet needs, is available. *Community Transportation in Texas*, a report published in 1998, provides the most comprehensive assessment of community transportation needs and services ever compiled. This report also contains recommendations for improving transportation services. This information can be useful to decision-makers because it provides the "big picture" of community transportation.

Sharing Information. The Office of Community Transportation Services periodically publishes several reports and provides information to assist providers in coordination activities:

- *Finding Transportation in Texas: A Guide to Publicly Funded Community Transportation* is particularly helpful to front-line workers, as it provides a directory of transportation providers and information contacts for each county in Texas.
- *Community Transportation Program Profiles* provides detailed information on each of the publicly funded programs. This includes data on funding and people served.
- A *Biennial Report on Health and Human Services Client Transportation in Texas* is prepared to summarize progress made and includes recommendations.
- Statewide information on conferences and training is available through the Internet.

Other information sharing to enhance coordination includes:

- The Texas Department of Transportation (TxDOT) and the health and human services state agencies share information with each other related to transportation providers and current contracts and resources for services within local areas.
- TxDOT is now required to include transportation needs of clients in their planning and funding activities.

All of these information activities have supported coordination of transportation at state and local levels. These activities provide the tools needed to achieve change.

CHECKLIST OF ACCOMPLISHMENTS

- ✔ Access to services and employment improved
- ✔ Resources used more efficiently
- ✔ Vision for community transportation services adopted
- ✔ *Community Transportation in Texas* published
- ✔ *Finding Transportation in Texas* published
- ✔ *Community Transportation Program Profiles* published
- ✔ Study on agency rules completed
- ✔ Database of agency rules developed
- ✔ Rule format proposed
- ✔ Statewide clearinghouse on training established
- ✔ Standard definitions adopted
- ✔ Regional boundaries identified
- ✔ Coordination pilot projects implemented

Community Transportation Services

Successes of the Transportation Coordination Models:

By working together, communities have figured out how to address different problems which has resulted in:

- sharing vehicles and other resources;
- coordinating schedules;
- combining routes and trips;
- changing rates;
- sharing dispatch activities;
- jointly purchasing fuel and maintenance agreements; and
- paving roads.

THE RESULTS

Simplifying Rules. A study of federal and state agency rules that govern transportation was completed in 1998. A major finding is that there are no rules which preclude coordination of transportation between agencies. How the rules are actually interpreted and locally applied may vary greatly.

A database of rule requirements for agencies has been created. This database is a tool for communities who are working to eliminate perceived barriers. A rule format for agencies is proposed to simplify requirements. Agencies voluntarily submit their proposed transportation rules to interagency review.

Uniform Practices. *Standard definitions* are now used by transportation programs. In addition to facilitating communication, these definitions form the basis upon which other shared activities can occur. For planning and coordination, *regional boundaries* have been recommended. The need for a *uniform rate structure* has been noted so that a current problem of providers being paid different amounts for the same service can be eliminated.

Methods that programs use for *reporting and evaluating* services also vary. The need to standardize reporting has also been identified so that the capacity to accurately define needs, assess services and expenditures can be improved.

Impact of Coordination. Coordination of services by communities has a dual impact. The people using services benefit because access to services and employment improves. Agencies and programs benefit because resources are used more efficiently.

Communities have learned that coordination is hard work. Coordination requires an investment of time - time that some feel they can ill afford as it takes them away from the job at hand. Agencies and organizations have their own objectives. To coordinate, a shared vision and broad purpose must be adopted. A willingness to change, to be flexible and creative are necessary.

WHERE DO WE GO FROM HERE?

☆ ***Investment in community transportation coordination*** is the key to stretching resources as needs continue to grow. A simultaneous top-down and bottom-up approach will support community efforts. The effectiveness in combining resources at the local level has been demonstrated. Through coordination, use of all resources can be maximized to better meet the growing needs for transportation.

☆ ***Local coordination efforts*** within communities will continue to be supported. The Office of Community Transportation Services will provide ongoing technical assistance to the five model sites as well as other communities interested in coordination. Results from these sites will be further analyzed. Lessons learned from local communities within Texas as well as national "best practices" will be compiled into a *Community Transportation Workbook* to be published in 1999. This document will serve as a practical "how-to guide" for other communities about what works.

☆ ***Statewide coordination efforts*** will focus on uniform practices. Specific approaches for a uniform rate structure will be pursued. The need for equity in rate formulas — how much is paid for same services — is clear.

☆ ***Standardizing the reporting and evaluation of services*** is a critical need. How a particular service is defined and measured for purposes of reporting must be the same so that common information, which avoids "apples to oranges" comparisons, can be available for decision-makers. For example, some programs count a "trip" from the point of origin to ultimate destination; other programs count intermediate stops on a route as a separate "trip." Costs and needs for service are also measured differently. Methods for achieving consistent reporting will receive special focus.

Specific mandates to adopt uniform practices would speed the ability to coordinate efforts.

☆ ***Consolidation of transportation rules*** will continue to be explored. While a rule format which simplifies requirements has been developed, its use is not required. Having fewer rules, or even one rule, about community transportation will make it easier to understand requirements and how they can be applied to achieve coordination.

TO-DO LIST

- ✪ Increase investment in community transportation coordination
- ✪ Publish the *Community Transportation Workbook*
- ✪ Support model sites and other local community coordination efforts
- ✪ Identify uniform rate setting methodology
- ✪ Standardize reporting and evaluation of services
- ✪ Consolidate transportation rules
- ✪ Maintain resource information through the Internet

THE CHALLENGE

Why do I have to go to so many places to get the help that I need? Why can't I go to one office?

Historically, most health and human services state agencies have independently set up offices. A single community can have many offices spread all over town. Further complicating the situation is the fact that health and human services provided by cities and counties often have separate offices as well.

People in need of services often require support from more than one agency. People may have to go from one office to the next to get help. Not only does this situation pose transportation problems for some consumers, it also means that the same type of information has to be provided repeatedly.

In addition, professionals may experience problems with this situation. It is difficult for agencies to eliminate duplicate functions when offices are scattered. For example, intake staff can not be shared unless such staff are physically located together. Coordination of services among agencies for a particular person or family can be difficult as well.

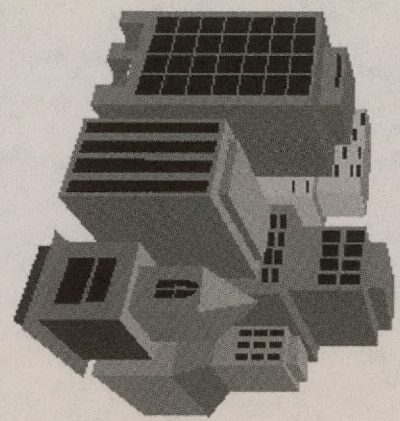
Opportunities for agencies to achieve "economies of scale" are also limited when there are multiple offices. Examples include janitorial and security services as well as sharing common space such as conference rooms and reception areas. Also, administrative costs can not be reduced by sharing office equipment like copier machines and telephone systems.

How many separate offices are there? In 1998, *1,247 offices* throughout Texas housed state agency staff. The majority of these offices used leased space. Often, these leases are for terms up to ten years.

To illustrate the barriers this creates, here is a **CASE IN POINT.....**

Ms. Rodriquez is a single mother who recently has recovered from a long illness which kept her from working. She is now ready to begin a job training program and walks to the office to sign up for training. To get child care services, she takes the bus to another office. She learned from a friend that she may be eligible for utility assistance so she goes to yet another office across town to apply for this service. One of her children has experienced problems at school and Ms. Rodriquez is referred to a mental health clinic which is not on a bus route and she has to take a cab. It takes Ms. Rodriquez a month to make these different trips as she has to arrange for child care and find a ride.

Staff at four different offices help Ms. Rodriquez. In each case, Ms. Rodriquez provides much of the same information about herself and her family and fills out similar paperwork. Staff at these offices are not aware of the other services that she is trying to access.



Co-Location of Services

Related Legislation in the Government Code:

Section 531.024 - Planning and Delivery of Services: Directs the Commissioner (of health and human services) to facilitate and enforce coordinated planning and delivery of services including co-location of services.

Related Legislation in the Human Resources Code:

Section 132.003 - Location of Offices and Facilities: Requires the Commission to determine, as leases on office space expire, the needs for space and location of offices to achieve a cost-effective service center method of health and human service delivery.

THE APPROACH

What is happening to address this problem?

Co-Location Workgroup. Recognizing the problems that exist with multiple offices, the 72nd Legislature required that agencies co-locate their offices to the greatest extent possible. Consequently, in 1992, representatives from the twelve health and human service agencies first came together to address how to increase co-location.

Through leadership provided by the Commission, this workgroup initially developed a working definition of co-location. Regional plans for co-location were developed, a process for reviewing leases was formulated, and tools to facilitate co-location efforts were developed.

This Workgroup continues to be the vehicle through which health and human service agencies plan and coordinate statewide efforts to promote co-location of offices.

Lease Review Process. Since 1993, each agency considering a new lease, lease renewal, or extension must coordinate with other health and human service agencies in their area to explore the feasibility of co-locating.

After exploring the possibilities for co-location, each agency submits lease information to the Commission for review. The Commission analyzes the lease request and either forwards approval to the General Services Commission or requests that the agency further examine co-location opportunities.

Tools. To assist agencies in their co-location efforts, the Commission maintains a *database* of lease information. The Commission also uses this database to analyze and report data to measure progress over time.

A number of practical issues arise when agencies co-locate offices. Issues include how to coordinate support functions, how to share space such as meeting rooms and reception areas, and how to split costs like utilities. Consequently, *Facility Management Guidelines* have been developed to assist agencies that operate in a co-located setting.

THE RESULTS

How has this made a difference?

Increases in Co-location. Demonstrating their commitment to co-location, health and human service agency commissioners have co-located operations at the state office level. Including the Commission, eleven of the twelve agencies are now co-located within the health and human services complex in Austin.

The number of local offices throughout the state that are co-located has steadily increased and exceeded the levels projected in regional plans. In 1993, it was estimated that approximately 33% of all offices were co-located. At the end of fiscal year 1998, 56% of all offices were co-located (701 of the 1,247 offices).

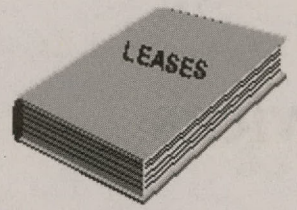
From May, 1993 through the end of fiscal year 1998, **796** lease requests for health and human services offices were processed by the Commission. Of these, **290 or 36.4%** were leases for co-located offices. Each year, at least 30% of the leases processed have resulted in co-location.

Characteristics of Co-location. The majority of these co-located sites (*454 or 63%*) are in state-leased buildings. Only 28 sites (*or 4%*) are in state-owned buildings. In both cases, some sites house staff who are not from health and human services agencies. For example, the Attorney General's staff may be co-located with the Texas Department of Human Services. Some of the health and human services sites (113 or 15%) are places where staff are located at no cost to the agency. These sites include hospitals, resource centers, and schools. There are other sites in which "itinerant" staff share space, meaning staff may travel and work out of different offices.

Additionally, there are 79 offices (*or 11%*) that are co-located by close proximity. While there are separate buildings, the agencies are located no further than one mile from each other.

Each agency has local offices participating in co-location. Agencies with the greatest percentage of co-located offices are the Texas Rehabilitation Commission, the Texas Department of Health, and the Texas Department of Protective and Regulatory Services.

Impact of Co-Location. From a consumer perspective, access to services has improved. People travel to fewer offices to get needed services. At sites in which common functions such as screening and intake have been integrated, the steps to apply for services are streamlined. The time it takes to get services can be shortened.



CO-LOCATION STATISTICS FOR FY98

701 (or 56%) of 1,247 offices are co-located:

- 321 sites are agencies in state-leased facilities
- 131 sites include non health and human service agencies in state-leased facilities
- 7 sites are agencies in state-owned facilities
- 21 sites include non health and human service agencies in state-owned facilities
- 113 sites are free space
- 79 sites are co-located by close proximity
- 25 sites are in other co-located situations
- 4 sites house itinerant staff

Co-Location of Services

CHECKLIST OF ACCOMPLISHMENTS

- ✔ Access and coordination of services improved
- ✔ Administrative and overhead costs reduced
- ✔ 56% of all offices co-located
- ✔ Lease review process in place
- ✔ *Facilities Management Guidelines* in use
- ✔ Database on co-location maintained

THE RESULTS

Less tangible, but important, are the benefits realized by staff through better understanding and knowledge of other agency programs. The opportunities to improve coordination of services among agencies are greater. For example, a worker now familiar with programs provided by a co-located agency can make more appropriate and timely referrals.

From an administrative perspective, cost-savings are realized. Listed below are some examples of equipment and resources that can be shared by agencies co-locating:

- telephone system
- copy and fax machines
- security equipment and services
- common area furniture
- janitorial services
- mail services
- recycling services
- switchboard and reception services
- printing/copier center
- automation support

To further illustrate co-location, described next is a **CASE IN POINT....**

Perhaps the largest co-location effort is in Fort Worth at a site called the Resource Connection. Using property which was previously a state school owned by the Texas Department of Mental Health and Mental Retardation , a mix of city, county, state, and private agencies are working together. This property contains a large complex of buildings, somewhat like a mall, that are used by the following agencies:

- *Tarrant County Human Services*
- *Tarrant County Housing Assistance Office*
- *Tarrant County Mental Health and Mental Retardation Services*
- *Tarrant County Veterans Services*
- *Tarrant County Sheriff's Office*
- *Tarrant County Hospital District: John Peter Smith Institute for Health and Career Development; John Peter Smith Health Center*
- *Resource Connection Career Center*
- *Fort Worth ISD: Adult Education Center; New Lives School*
- *Disability Services of the Southwest*
- *Community Health Foundation*
- *Easter Seals Society for Children and Adults*
- *Texas Department of Human Services*
- *Texas Department of Protective and Regulatory Services*
- *Texas Rehabilitation Commission*
- *Texas Commission for the Blind*
- *Texas Department of Housing and Community Affairs*

People needing services can travel to the Resource Connection on the city bus and access a variety of services in this one location.

WHERE DO WE GO FROM HERE?

☆ ***Co-location will increase*** over time as agency leases expire. The process for assessing opportunities for co-location will continue to be used by health and human service agencies.

Co-location of all offices is not expected because in some communities, only one state agency may have an office. In other communities, the timing of lease expirations is such that coordination is difficult to achieve. And finally, in some situations, existing lease rates can be extended at a cost below that of negotiating a new lease with other agencies.

☆ ***There are other factors which impact future co-location.*** The need for lease space may decrease as agencies provide more contracted services rather than direct services. Some agencies may not be able to negotiate longer term leases with lower rates because of anticipated program and staff changes. Additionally, the status of the economy and associated market dynamics within a community affect the cost of leased space.

The number of leases expected to expire through the year 2005, is significantly less than the number that expired during the preceeding five year period. Therefore, with fewer leases expiring, there may be fewer opportunities for state agencies to consider co-location.

There continue to be opportunities, however, for increasing co-location with local and private agencies, particularly with community-driven initiatives such as one-stop service centers. State regulations regarding co-location with non-state organizations will have to be examined.

Implementation of the *Texas Integrated Enrollment and Services (TIES)* initiative will affect co-location opportunities *(see discussion of the TIES initiative beginning on page 16).* For instance, several agencies will jointly conduct the application and eligibility process through call centers.

It is also anticipated that agencies currently co-located can continue to explore options for additional coordination of services and consolidation of administrative supports.

In conclusion, co-location will continue to be a method for achieving cost-savings and for improving access to and coordination of services.

For additional information, contact:

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The following report is available:

Co-Location of Health and Human Services Offices in Texas (1996)

THE CHALLENGE

How can agencies coordinate and enhance their Internet sites to provide technical assistance?

Effective and timely communication is an important function of all health and human services agencies. Human services providers, as well as the general public, often seek general information such as hotline phone numbers, job postings, education and training opportunities, and grant or contract opportunities.

Technical information is sought by providers, especially those delivering services on behalf of agencies. This can include information about rules and rule changes, provider eligibility, contract requirements, and minimum standards.

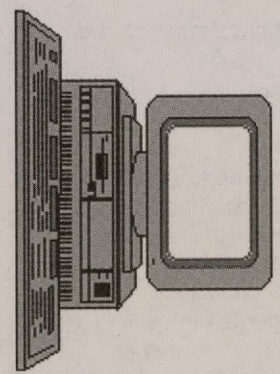
Agencies use several forums for supplying information to providers and the public. Information is distributed through written materials, over the telephone and face-to-face contacts.

With the advent of the Internet, a relatively new forum for exchange of information is available. Agencies have taken the initiative to create Internet sites. However, agencies have independently developed these Internet sites. There has not been a coordinated interagency plan to guide this activity. Consequently, the kinds of information posted on Internet sites varies and may be duplicated.

Questions have been raised about how to best coordinate Internet services and about the cost-effectiveness of providing additional technical assistance via the Internet.

The 75th Legislature recognized the potential importance of using the Internet as a method to provide technical assistance. The health and human services agencies, in conjunction with the Department of Information Resources, were directed to coordinate and enhance their existing Internet sites to provide technical assistance to human services providers.

The Commission was directed to take the lead and to involve those agencies with the greatest potential for cost-savings.



Electronic Technical Assistance

Related Legislation in the Government Code:

531.013 - Electronic Availability of Technical Assistance: Directs the health and human services agencies, in conjunction with the Department of Information Resources, to coordinate and enhance their existing Internet sites to provide technical assistance to human services providers.

Assistance may include information about case management, contract management, financial management, performance evaluation, and research. It must include information on the impact of federal and state welfare reform changes.

A legislative report regarding the cost-effectiveness of using the Internet shall be submitted no later than September 1, 1998.

THE APPROACH

What is happening to address this problem?

Interagency Workgroup. In 1998, the Commission formed a workgroup of representatives from various agencies to address the requirements of the legislation. Agencies participating in this technical assistance workgroup included:

- Health and Human Services Commission
- Texas Department of Information Resources
- Texas Commission for the Blind
- Texas Commission on Alcohol and Drug Abuse
- Texas Department of Health
- Texas Department of Human Services
- Texas Interagency Council on Early Childhood Intervention
- Texas Department of Mental Health and Mental Retardation
- Texas Department of Protective and Regulatory Services
- Texas Workforce Commission

Catalog of Internet Use. The first task of the workgroup was to exchange information about current uses of Internet sites. This involved categorizing types of technical assistance and information sharing activities. Also included was the identification of activities planned for the future.

Analysis of Benefits and Limitations. The workgroup identified and analyzed the various benefits as well as the limitations of using the Internet to provide information and assistance. The Internet is a user-friendly and convenient technology. It offers an efficient method for providing information and assistance. The effort required to maintain an effective Internet site can often be underestimated.

Interagency Planning. The final task of the workgroup was to make recommendations for interagency planning. By working together, agencies can learn from each other and reduce duplication and effort. The workgroup identified recommendations and activities that would enhance coordination of Internet sites for health and human services.

In September, 1998, the workgroup submitted a report to the 75th Legislature to address the requirements of the legislation. Highlights from this report appear on the next three pages.

THE RESULTS

How has this made a difference?

Assistance Currently Available. The analysis by the workgroup indicates that agencies are using the Internet to improve communication, to provide information, and to respond to the needs of providers and the public. Use of the Internet varies greatly across agencies as does the ability of providers to access the Internet.

All agencies participating in this analysis maintain Internet sites and provide basic information of interest. Information includes resource directories of providers and services, statistics, phone numbers and job listings. Technical information is available as well such as the impact of federal and state welfare reform changes and descriptions of best practices.

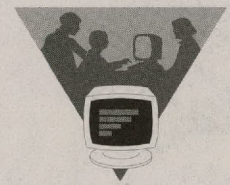
Some agencies have developed more sophisticated uses that have improved access to information and to varying degrees have yielded cost-savings. Here are a few **CASES IN POINT...**

The Texas Department of Protective and Regulatory Services has used the Internet to provide a monthly listing of children available for adoption to recruit potential adoptive parents. The site includes about 375 pictures and descriptions of children every month and information on foster care and adoption. In May, 1998, for example, this site received over 9,000 "hits" by over 8,000 visitors. This has extended the ability of the agency to reach more people who may be interested in adoption.

In the past, copies of birth certificates could only be obtained through the state office in which they were born. Now, the Texas Department of Health allows local registrars to link their offices through the Internet to the vital statistics birth data base. This provides convenient and timely access to certified abstracts of birth for identification purposes. Local registrars benefit from revenue brought in for this service and the public benefits from a more convenient process.

The Health and Human Services Commission used to publish lists of providers that were excluded from participation in the Medicaid program in local newspapers across the state. Also, monthly updates had to be mailed to designated entities. This information is now posted on the Internet site and the agency saves newspaper, copying, and postage costs which equal about $26,400 a year.

The Texas Department of Protective and Regulatory Services has launched the Texas Child Care Search that may be the largest web site of its kind in the nation. This site contains information from a database of about 20,000 child-care facilities in Texas. By entering a zip code, users may obtain a listing of child-care providers in that area which includes facility name, address, phone number, and ages of children served.



EXAMPLES OF INFORMATION AVAILABLE THROUGH THE INTERNET

General:

- Grant and Funding Opportunities
- RFPs and Notices of Intent
- Resource Directories of Providers/ Services
- Statistics
- Needs Assessment Tools
- Hotline phone numbers
- Job Listings
- Agency Personnel Directory
- Fact Sheets, Notices, Alerts
- Library/Clearinghouse Information or Services
- Calendar of Events

Technical:

- Rules/Rule Changes
- Frequently Asked Questions
- Education and Training
- Best Practices
- Case Management/Referrals
- Provider Manuals, Handbooks or Publications
- Provider Eligibility, Requirements, or Standards

Electronic Technical Assistance

THE RESULTS

In general, agencies are only beginning to use Internet technology. All agencies have plans to expand the information posted on their Internet sites. The opportunity to share information between the agencies stimulated ideas about how to better assist providers.

Is it cost-effective? There is no question that information can be shared through the Internet more efficiently than through traditional methods such as phone calls or the mail. Expenses such as printing, paper, postage, and costs for staff time can be reduced.

Use of the Internet though does not necessarily eliminate the need for traditional means of communicating to remain in place. Many providers, as well as the public, do not have access to the Internet or prefer not to use it.

There are costs associated with an Internet site. It is labor intensive to establish, maintain, and keep updated with current information. Some agencies do not have staff dedicated to perform these functions, rather they are done in addition to other job duties.

Initially, the use of the Internet to provide information and technical assistance may not save money. It can certainly be more convenient to providers and the public. Information can be immediately obtained and more information can be accessed than through traditional communications.

WHERE DO WE GO FROM HERE?

☆ ***Use of the Internet to provide technical assistance*** will continue. Each agency plans to expand the information available through its web site. Agencies may be challenged though to maintain quality Internet services without designated employees to coordinate this operation. As the complexity of a web site increases, the technical skills needed by staff will increase.

☆ ***Web site links*** are being established by the agencies. This means that one agency links its web site to the other health and human services agencies and to related agencies. This makes it easier for people to find information they are seeking. Agencies are encouraged to establish links with TRAIL, the Texas Records and Information Locator maintained by the Texas State Library.

☆ ***Resource directory*** information is also being linked to agencies' web sites. The Commission includes *Finding Help in Texas: A Directory of Information and Referral Providers* on its web site. This directory is a comprehensive listing of information and referral providers for local, regional and state health and human services information. Linking it to agency web sites can be particularly helpful to consumers who are trying to get connected to services.

☆ ***A permanent interagency group*** has been recommended and will be considered for future action. Such a group could be established with representatives of the health and human services agencies to create consistent policies and practices of Internet use among agencies. This approach will facilitate coordination, information sharing and standardization. Overall, the results will be expanded and improved Internet services.

Staff resources are needed to coordinate cross-agency Internet services. A dedicated staff person to lead the coordination of Internet use across the agencies would improve Internet services and reduce duplication of efforts.

For additional information, contact:

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(512) 424-6518
Fax (512) 424-6588

The following report is available:

Electronic Availability of Technical Assistance (1998)

LONG-TERM SERVICES

- Long-Term Services and Supports
- Guardianship Alliance of Texas
- Children with Disabilities

THE CHALLENGE

What assistance is available for a 75 year old woman living at home alone? Who can help a 32 year old man paralyzed from an accident? What are the options for taking care of a 2 year old child with complex medical needs?

Texans of all ages with different disabilities may need long-term services and supports at some point in their lives. Long-term services and supports are defined as *"the provision of health care, personal care, and assistance related to health and social services over a sustained period to people of all ages and their families, regardless of the setting in which the care is given."*

A physical or mental impairment that interferes with a person's ability to live independently can create a need for an array of long- term services and supports. Spinal cord injury, stroke, Alzheimer's disease, mental illness, cerebral palsy, AIDS, and mental retardation are just a few examples of conditions that can cause a person to need assistance. Limitations on a person's ability to function can arise at any time — from birth, from an illness or accident, or as a result of aging.

In general, long-term services and supports help people with basic functions of daily living such as eating, dressing, bathing, and toileting. Also included is assistance with other activities important to independence such as cooking, cleaning, shopping, taking medicine, working, and driving. Some services and supports are specialized like physical therapy, skilled nursing, psychological services, and assistive technology.

Severity of need varies greatly. Some people need occasional assistance and others require substantial lifelong supports. For example, one person may need weekly transportation to doctor's appointments or monthly monitoring of medications. In contrast, another person may need "around the clock" nursing, specialized medical equipment, or daily therapies.

Long-term services and supports are available in different settings. Many services and supports are provided in people's homes or within their community in adult day care centers, churches, senior centers, at work and school. Residential settings such as nursing homes, assisted living facilities, state hospitals, small group homes, and foster homes are examples of places outside the personal home where long-term services and supports are provided.

Long-Term Services & Supports

For additional information, contact:

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www.hhsc.state.tx.us/si/ltcp/index.htm

Reports available include:

An Assessment of the Design and Delivery of Long-Term Services and Supports (1998)

Texas Long-Term Care Plan (1998)

Combining Community-Based Waivers: A Feasibility Study (1998)

Agency Coordination Task Force Report (December, 1998)

THE CHALLENGE

How many people need long-term services and supports? In 1998, there are an estimated *3.7 million* Texans with disabilities. Included in this estimate are people of all ages with functional disabilities including persons ages 65 and older in need of assistance with daily living. It is projected that in 2005, there will be *4.3 million* Texans with disabilities.

The largest proportion of this population includes persons ages 65 and older. While not all elderly people need publicly funded long- term services and supports, the need intensifies significantly with age, especially after age 85. As "baby boomers" age, it is projected that the population of elderly people will actually double over the next 25 years.

One factor for determining eligibility for services and supports is low income. In 1998, it is projected that there are **569,200** adults with low income who are elderly and functionally disabled. It is projected that in 2004 there will be **602,800** people, an increase of 33,600 people. It is assumed that the number of people at risk of nursing home care ranges from one-third to one-half of that population.

The number of children and working-age adults with functional disabilities who have a low income also is expected to increase. It is projected that this population may grow by 28,500 from **423,100** in 1998 to **451,600** in 2004.

Other sub-populations are also expected to increase. For example, the number of people with mental retardation is projected to grow by some 58,000 from **536,000** in 1998 to **594,000** in 2004. The population in need of mental health services may grow by 314,000 from **2.9 million** in 1998 to **3.2 million** in 2004.

Thus, due to the expected population growth trends over the next few years, it is projected that the overall need for long-term services and supports will increase.

What are the major issues in providing services and supports? An overarching issue is the number of different programs. There are 46 separate programs for long-term services and supports that are provided by seven state agencies. Generally, the services offered or the people served differ from agency to agency. Some agencies use local government entities to administer programs and others have branch state offices. Some agencies contract for services while others provide services directly.

THE CHALLENGE

Access to services can be a significant barrier. Funding sources for the various programs dictate different eligibility requirements generally focused on age, diagnosis, severity of disability, and income. Eligibility assessments completed for one program may not be applicable to other programs.

The eligibility criteria create a complex patchwork of services. Some people are precluded from participating in programs even if they have needs that could be met by the program and even if they can not afford to pay for services. For example, a person may not have the "right" diagnosis or may have more financial assets than allowed even if they do not have disposable income to pay for a particular service.

Further, even if a person is eligible for services, he or she may not receive services because of funding limitations. Many programs create waiting lists when funds run out.

People needing long-term services and supports must figure out and maneuver through a complicated system. There is not one place to go to or one phone call to make for services. People have to learn which agency may have services for their particular condition or disability.

The array of services offered by programs varies. Few programs offer a full array of services available in both community and institutional settings.

A full array includes services such as personal assistance, home modifications, transportation, respite, meals, hospice care, medical equipment, assistive devices, habilitation, residential services, and case management.

If some of these services are not available, it increases the likelihood that a person may develop more serious problems that ultimately require more expensive services. Gaps in services may also exist because of eligibility criteria.

Coordination of long-term service delivery and administration is limited. Agencies have different service delivery approaches as well as different values such as flexibility of consumers to choose services. The rates

NEED FOR LONG-TERM SERVICES AND SUPPORTS

In 2004, it is projected that there will be....

- **602,800** adults with low income who are elderly and functionally disabled
- **451,600** children and working-age adults with functional disabilities and low income
- **594,000** people with mental retardation
- **3.2** million people with mental illness

THE CHALLENGE

used to reimburse providers for the same type of service such as nursing can vary among programs as can accountability or quality assurance systems.

Overall, the long-term services system in Texas is fragmented and complicated. The need for long-term services has far outpaced the available resources. Agencies will continue to be challenged by the growth of the populations of people at the greatest risk of needing long-term services. Clearly, resources must be maximized and expanded whenever possible.

THE APPROACH

What is happening to address this problem?

Long-Term Care Plan. Since 1993, the Commission has led the effort to coordinate long-term services and supports among the agencies. A Long-Term Care Task Force of advocates, providers, and state agency staff developed a definition and vision for long-term care, which was adopted by the 74th Legislature. The Commission was directed by the 74th and 75th Legislatures to develop plans to coordinate long-term care service delivery and administration.

The recommendations from the Task Force report have continued to guide coordination activities of the agencies providing long-term services and supports. In 1996, the agencies developed a long-term care plan based upon this report and held a public hearing to update information. The plan was reviewed and revised in 1998.

The 1998 plan identifies five objectives to build the long-term care system in Texas. To support each objective, agencies identified strategies and initiatives. The objectives are:

- Better *coordination* of service delivery and administration.
- Increasing *access* to services
- Expanding the available *array* of services to include more community-based options.
- Providing *quality services* that maximize independence and autonomy of the individual.
- Maximizing *resources* through funding strategies that support consumer choice.

Assessment of Long-Term Services and Supports. As a continuation of the agency work to coordinate long-term services and supports, the Commission initiated a process to analyze agency programs in 1998. The purpose is to assess the variation in the design and delivery of services to identify methods to achieve greater consistency across the programs.

This assessment included several analyses. First, each agency program was classified according to the statutory definition of long-term care. Detailed program data for fiscal year 1998 were collected as well as information related to the statutory guiding principles for long-term care. Next, the data were analyzed to identify variations across programs and the sources of such variation. As a result of this analysis, methods to increase consistency across organizational lines were identified.

Related Legislation in the Government Code:

531.043 - Long-Term Care Vision: directs the Commission to develop, in conjunction with the appropriate state agencies, a plan for access to individualized long-term care services for persons with functional limitations or medical needs and their families. Guiding principles and goals of the plan focusing on the individual and the individual's family as well as the delivery of services are stated. Long-term care is defined.

531.003 - Functional Assessment: directs the Commission to develop a functional needs assessment pilot program to determine feasibility of using a consistent process for long-term services programs.

531.021 - Waiver Consolidation: requires the Commission to study the feasibility and advisability of combining existing Medicaid waiver programs.

Long-Term Services & Supports

TEXAS VISION FOR LONG-TERM CARE

It is the vision of the people of Texas that each person who has functional limitations will have access to individualized long-term care services of his or her choice that will assist the person in maintaining and achieving the greatest possible independence, autonomy, and quality of life. It is the policy of the state that children should grow up in families and that persons with disabilities and elderly persons should live in the setting of their choice.

THE APPROACH

Combining Community-Based Waivers. Federal law allows states to apply for waivers of certain Medicaid requirements. One waiver (1915[c] of the Social Security Act) relating to long-term care allows states to provide home and community-based services to people who qualify for care in an institution. Texas has eight such waiver programs each of which has a particular service package and different eligibility requirements.

The 75th Legislature directed the Commission to study the feasibility of consolidating the state's Medicaid long-term care 1915(c) waiver programs. The Long-Term Care Task Force had recommended that these programs be collapsed into a "smaller number of more inclusive waivers that offer similar service arrays" and that eligibility be based on functional need rather than diagnosis.

The Commission convened a workgroup of representatives of advocacy groups and state agencies providing services and supports to study the feasibility of combining the waiver programs. The workgroup identified issues associated with consolidation and developed strategies to address the issues. Recommendations of the workgroup were broadly disseminated for comment and a public hearing was held to obtain input.

Special Initiatives. Other activities are underway to test the effectiveness of delivering services in innovative ways.

- ***STAR+PLUS:*** As part of the Medicaid managed care program in Texas, the Commission is piloting a program to integrate delivery of long-term services and supports with acute health care services. Referred to as the *STAR+PLUS* program, this pilot is serving people in Harris County who are eligible for Medicaid services and who are aged and disabled. People began enrolling in this program in February, 1998.

- ***Functional Needs Assessment:*** The 75th Legislature directed the Commission to develop a *functional needs assessment* pilot program to determine the feasibility of agencies using a consistent eligibility process. This process would determine a person's eligibility for services on the basis of functional needs rather than diagnosis.

It is projected that a functional needs assessment would improve access to services, open the door for other people in need of services, and allow the State to plan and deliver services based on service needs across all populations rather than having to plan similar services for separate populations. The pilot program will test these assumptions.

THE APPROACH

The Commission contracted with the University of Texas at Houston Health Science Center to develop and pilot the functional needs assessment process with input from consumers, advocates, providers, and state agencies.

■ ***Project CHOICE:*** The State's vision for long-term care reinforces that services and supports will be provided in the setting chosen by the person. Even though community-based options have been developed as an alternative to institutional services, there are barriers to the full use of these options. For example, it can be quite difficult for someone living in a nursing facility to transition back into the community. Often, entry into services is an emergency that leads to people entering nursing facilities or other institutions because community-based services could not be accessed quickly enough.

To address the barriers related to consumer use of community-based options for long-term services and supports, the Commission sought and received a federal grant from the Health Care Financing Administration. This initiative, referred to as *Project CHOICE* (**C**onsumers **H**ave **O**ptions for **I**ndependence in **C**ommunity **E**nvironments), will test the effectiveness of strategies designed to eliminate barriers to community services. The initiative targets people currently living in nursing facilities who want to return to community living and people at risk of nursing facility placement who want to continue to live in the community.

■ ***Agency Coordination Task Force (ACT):*** The ACT initiative is a joint project facilitated by the Commission to standardize administration of similar programs of the Texas Department of Human Services and the Texas Department of Aging.

The Task Force recommended standardization regarding contracts, rules, and rates for congregate meals, personal assistance, adult day care, and emergency response programs.

AGENCIES PROVIDING LONG-TERM SERVICES AND SUPPORTS

- Texas Department of Aging
- Texas Department of Protective and Regulatory Services
- Texas Interagency Council on Early Childhood Intervention
- Texas Department of Health
- Texas Department of Human Services
- Texas Department of Mental Health and Mental Retardation
- Texas Rehabilitation Commission

Long-Term Services & Supports

THE RESULTS

How has this made a difference?

Impact of Planning. Numerous improvements and changes have occurred in the long-term services and supports system since 1994 when the first statewide report was published by the Long-Term Care Task Force. The agencies providing services and supports have initiated a broad range of individual and collaborative actions including policy revisions, administrative changes, expansion of services, and testing implementation of different service models or approaches. Listed below are a few **CASES IN POINT...**

✣ *The Texas Department of Human Services (TDHS) and the Texas Department of Health (TDH) developed an agreement to allow some funds allocated to TDHS for the cost of nursing facility care for children to be transferred to a TDH program so that the children who move out of the nursing facility can be served in the home.*

✣ *TDHS has implemented an automated assessment tool that eliminates administrative duplication and speeds the process of eligibility certification and service authorization.*

✣ *The number of people served through Medicaid waiver programs has increased dramatically during the past four years. More people can receive long-term services and supports within their community rather than institutional settings.*

✣ *A voucher system to pay for personal assistance services and respite care is being piloted through cooperative efforts of the Texas Department of Human Services, the Texas Rehabilitation Commission and the Comptroller's Office.*

Waiver Consolidation. The Commission issued a report, *Combining Community-Based Waivers: A Feasibility Study* to the Legislature in December, 1998. Included in the report is a recommendation to pilot consolidation of Medicaid waiver programs in a limited geographic area. The pilot will test the extent to which diverse populations can be well-served by a single program. Also tested will be the use of a functional assessment process to determine eligibility and allocation of resources.

The cost for operating a pilot from fiscal years 2001 through 2003 is estimated at $5.5 million per year to serve 200 people.

Another recommendation is to make certain functions of existing waivers more consistent, regardless of waiver consolidation considerations. Specifically, a single database for all waiting lists should be developed to provide accurate reporting of service need.

THE RESULTS

Assessment Results. In December, 1998, the Commission published a report, *An Assessment of the Design and Delivery of Long-Term Services and Supports*. General findings of the assessment indicate that there are 46 agency programs in seven agencies that provide long-term services and supports.

According to 1998 information, these programs serve approximately 900,000 people with over 800,000 (89.5%) receiving community-based services and about 95,000 (10.5%) receiving residential services. Total funding for the 46 programs is $4 billion; $2.3 billion for residential programs and $1.7 billion for community based services. Approximately 53% of the funding is federal and 44% is general revenue.

Data indicate that residential services, especially institutions, are more costly than community-based services — 10.5% of people using long-term services are in institutional settings using 56.5% of the funds.

Among eligibility groups, other findings indicate that:

- **Persons over Age 60:** Almost 358,000 people are served through TDHS and TDoA programs with 83.5% in community settings and 16.5% in nursing facilities. Annual cost for services is about $1.8 billion; approximately 31.2% of the total dollars is for community based services and 68.8% is for nursing facilities.

- **Persons with Physical Disabilities:** Over 52,000 adults under age 60 or 65 with physical disabilities receive services from TDHS, TRC, and TDH. Over 263,000 children with physical disabilities receive services. Approximately 98% are served in community settings with 2% in nursing facilities. Annual cost for services is approximately $527 million with 74.4% spent on community-based services and 25.6% for nursing facilities.

- **Persons with Mental Illness:** Approximately 158,000 people are served through TDMHMR programs with 82.9% in community settings and 17.1% in residential facilities. Annual cost for services is about $563.5 million; approximately 55.6% of the total dollars is for community-based services and 44.4% is for residential services.

EXISTING WAIVER PROGRAMS

Medically Dependent Children's Program: Serves 750 children under 21 who qualify for nursing facility services.

Community Living Assistance and Support Services: Serves 1050 people with developmental disabilities who qualify for ICF-MR services.

Home and Community-Based Waiver Services: Serves 4600 people with mental retardation who qualify for ICF-MR services.

Home and Community-Based Waiver Services OBRA: Serves a specific group of 150 people who were inappropriately placed in nursing facilities and who qualify for ICF-MR services.

Deaf Blind, Multiply Disabled: Serves 100 adults with multi-sensory conditions who qualify for ICF-MR services.

Community-Based Alternatives: Serves 22,000 adults who qualify for nursing facility services.

STAR+PLUS: Serves 600 enrollees in a managed care project which also provides acute care.

Mental Retardation Local Authority Pilot Project: Serves 600 people with mental retardation in seven pilot counties.

Long-Term Services & Supports

FUNDING FOR LONG-TERM SERVICES

FEDERAL DOLLARS:

Over Age 60: $1.1 B
Physical Disabilities: $310 M
Mental Illness: $80.3 M
Mental Retardation: $564.4 M

GENERAL REVENUE DOLLARS:

Over Age 60: $640 M
Physical Disabilities: $201 M
Mental Illness: $454.2 M
Mental Retardation: $438.5 M

TOTAL DOLLARS:

Over Age 60: 1.8 B
Physical Disabilities: $527 M
Mental Illness: $563.5 M
Mental Retardation: $1 B

THE RESULTS

- **Persons with Mental Retardation:** Almost 36,000 people are served through TDMHMR programs with 60% in community settings and 40% in residential programs. Annual cost for services is slightly more than $1 billion; approximately 37% is for community-based services and 63% for residential programs.

With respect to accessing services, the analysis indicates that 16 programs provide case management services, 14 programs provide transportation services, and 18 programs use a standardized assessment form.

The array of services provided by each program was analyzed according to eight service categories. Of the 46 programs, 35 provide related supports, 32 provide medical professional services, 31 provide personal assistance, and 28 provide assistive technology or adaptive aids. Less than half of the programs provide services in each of the remaining categories of job supports, prescription medications, case management, and residential services.

Rates for specific services were examined. The rates for personal assistance are generally uniform across programs. Other service rates vary greatly, with respite and nursing services having the most disparity.

Overall, the analysis of programs that provide long-term services and supports indicates similarities as well as differences in the services provided, the populations served, the service design, and the rates paid for specific services. Agencies are now working to address the differences as appropriate.

WHERE DO WE GO FROM HERE?

☆ ***Further assessment of long-term services and supports*** will be conducted by the Commission and the agencies in 1999. The first step in this assessment will be to examine in greater depth the inconsistencies in the design and delivery of services and the reasons for such differences. For example, one population may require more intensive services than other populations or the level of professional services needed may vary. Funding streams may limit agencies' flexibility in delivery of services.

A second step is to determine specific improvements and administrative efficiencies that will result through coordination across programs. Areas of focus include:

- **Rate Setting for Similar Services.** Differences in rates reported for similar services will be further examined to identify why such variances exist. These services may include: respite, nursing, physical therapy, occupational therapy, and speech pathology services. Potential justification for rate discrepancies includes differences in service definitions and components, regional variation in the cost and availability of certain providers, economies of scale and federal regulations dictating necessary service components. Where indicated, steps will be taken to make rates and rate setting processes more consistent so that services are more equitable and efficient.

- **Service Delivery Approach.** Uniform practices with respect to program goals and outcome measures will be addressed. Agencies will examine the implementation of principles related to consumer choice, participation, and autonomy. Agencies will incorporate common outcome measures and monitoring processes into operations where indicated.

- **Access.** A single functional needs assessment instrument for use in many programs that provide long-term services and supports will be tested beginning in 1999. Results of the pilot will be reported in 2000. Agencies are working to establish uniform practices concerning the initial connection that consumers make when seeking services. Other areas for review include case management and transition between programs.

TO-DO LIST

- ✪ Determine specific improvements and administrative efficiencies through coordination across programs
- ✪ Pilot functional assessment tool to determine eligibility
- ✪ Pilot waiver consolidation
- ✪ Continue implementation of *Project CHOICE*
- ✪ Continue the *STAR+PLUS* pilot and conduct evaluation
- ✪ Implement the Agency Coordination Task Force recommendations

Long-Term Services & Supports

WHERE DO WE GO FROM HERE?

☆ ***Waiver consolidation will be piloted***, assuming funding by the Legislature. It is recommended that the pilot should include a single functional assessment for eligibility and resource allocation, administration by a single entity, independent case management, and a common service array and rates for all participants. The 200 participants will include children and adults from the diverse populations served by existing waiver programs.

It is recommended that development of the pilot begin in 1999 with implementation scheduled for 2001 after the functional assessment process has been tested. An independent third party will evaluate the pilot for cost effectiveness and quality. As indicated by the evaluation results, expansion of the pilot will be considered.

☆ ***Project CHOICE is being implemented*** and services will begin in 1999. This project will test the extent to which barriers to community-based services can be removed for approximately 500 people at risk of nursing facility placement or who seek to return to community living from a nursing facility. Strategies included in the project include a presumptive eligibility mechanism to speed entry into community services, transition grants to pay people for expenses related to moving from nursing facilities to community services, and outreach strategies.

The effectiveness of the project will be assessed by federal evaluators. This information will be used to develop a plan to expand effective strategies and determine applicability of this overall approach with other populations.

☆ ***The STAR+PLUS pilot will continue*** in 1999. An evaluation of the pilot will be conducted after two full years of operation. A report of the evaluation will be submitted to the Legislature in July, 2000.

☆ ***Agency Coordination Task Force*** recommendations will provide the basis to standardize administration of similar programs provided by the Texas Department of Human Services and the Texas Department of Aging. Uniform administration will promote program consistency.

THE CHALLENGE

Who can help an elderly man with financial affairs who is too ill to make his own decisions? Who can consent to medical treatment for a woman with mental retardation who is not able to make these decisions?

Many Texans find themselves in a position where they are unable to make important decisions about their life — where to live, how to spend money, how to manage health care needs. A physical or mental condition may not allow a person to make responsible decisions on their own and to understand the consequences of those decisions.

There are a variety of conditions that may limit a person's ability to make informed decisions. Alzheimer's disease, other forms of dementia, stroke, mental illness, mental retardation, head injury, severe illness, and physical incapacity are the most common examples.

Substitute decision-makers or guardians are needed to assist the person and to protect his or her rights and liberties. Without guardians, people may be subjected to self-neglect and personal and financial exploitation.

The Texas Probate Code establishes a court procedure for guardianship. A court decides if a person is "incapacitated" and if so, decides who should make decisions on behalf of the person. The legal definition of "incapacitated person" is *"an individual who, because of a physical or mental condition, is substantially unable to provide food, clothing, or shelter for himself or herself, to care for the individual's own physical health, or to manage the individual's own financial affairs."*

Based upon each person's capacity to manage his or her own affairs, the court further determines the kinds of decisions (housing, medical, financial) a guardian makes and the extent of authority (limited or full) of the guardian. Some individuals may only need assistance with money management whereas others many need total decision making assistance.

Who serves as guardians? Generally, family members and friends are in the best position to serve as guardians. But, some people do not have family members or other individuals who can assume this responsibility. When this occurs, some communities have local guardianship programs, either paid workers or volunteers, who may be appointed. Additionally, private professional guardians may be

GUARDIANSHIP ALLIANCE OF TEXAS

Guardianship Alliance of Texas

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The following report is available:

Report to the Governor and the 75th Legislature on Guardianship Issues (1998)

THE CHALLENGE

appointed. In communities where such local programs do not exist, the court may appoint the Texas Department of Protective and Regulatory Services (TDPRS) or a local attorney as guardian. Additionally, TDPRS is appointed as guardian for people who have experienced abuse, neglect, or exploitation and for young adults previously receiving protective conservatorship.

How many people have guardians? There are approximately 47,000 people in Texas who have guardians. Of this number, guardianship programs serve as guardians for 2,400 individuals. The number of people potentially in need of guardians is expected to grow significantly within the next 20 years as the population of "baby boomers" ages and the number of people with disabilities increases.

Many people in need of guardians are individuals living in nursing facilities, group homes, state schools, and state hospitals and depend on governmental benefits to pay for housing and medical care.

The challenges associated with guardianship relate generally to the tremendous need that exists in communities. The most significant issues include:

1. Family members or friends interested in serving as guardian may not have the financial resources to pay court costs and expenses to hire an attorney (approximately $1,700) to get appointed.

2. Texas does not have a system to provide guardianship when a person does not have a suitable family member to serve in this capacity.

3. Courts may not be aware of people who need guardians but do not have family members pursuing guardianship on their behalf. These individuals may be at-risk for abuse, neglect, or exploitation.

4. Less restrictive alternatives to guardianship may be appropriate for some individuals but these programs are not available in most counties.

THE CHALLENGE

❺ Currently, there are no statewide standards or requirements concerning guardians and guardianship programs to ensure that uniform quality services are provided throughout the State.

To help illustrate some of these problems, here is a **CASE IN POINT....**

There are probably other people in Texas like Mr. Anderson. *He is 85 years old and lives in a nursing facility since he had a stroke. He has outlived his wife and two of his three children. His son, Mark, had been Mr. Anderson's guardian before Mark's death two years ago. His daughter, Sue, would like to become a successor guardian but does not have the money needed to hire an attorney and she is in poor health herself. Mr. Anderson needs a guardian to assist him with his financial affairs and medical decisions. Since it isn't possible for Mr. Anderson's daughter to pursue guardianship, a social worker at the nursing facility contacts the county court because needed medical procedures for Mr. Anderson have been delayed for many months. Because there is not a local guardianship program in this county, the court eventually appoints TDPRS as guardian after required evaluations and hearings are completed. In the meantime, Mr. Anderson's health has declined due to delays in medical treatment.*

TYPES OF GUARDIANSHIPS

Guardian of the Person: Makes housing and medical decisions for incapacitated persons.

Guardian of the Estate: Makes financial decisions for incapacitated persons.

Guardian of the Estate and Person: Makes housing, medical, and financial decisions for incapacitated persons.

Guardianship Alliance of Texas

> ***Related Legislation in the Government Code:***
>
> **531.122 - Guardianship Advisory Board:** Authorizes the Commission to establish an advisory board composed of one representative from each of the health and human services regions who are appointed by judges of statutory probate courts.
>
> **531.124 - Commission Duties:** Directs the Commission, with the advice of the advisory board, to adopt minimum standards regarding guardianship and to develop and implement a plan to address guardianship needs and foster growth of local volunteer guardianship programs. The guardianship plan is to be reported to the governor and 75th Legislature by December 1, 1998.
>
> **531.125 - Guardianship Grants:** Allows the Commission to award grants to establish local volunteer guardianship programs.

THE APPROACH

What is happening to address this problem?

Guardianship Alliance of Texas. Responding to the need for a statewide guardianship system, the 75th Legislature directed the Commission to perform several duties which include:

- ☑ adoption of *minimum standards* for guardians and guardianship programs;
- ☑ development and i*mplementation of a plan* to ensure that people receive guardianship services as needed; and
- ☑ establishment of an *advisory board* to assist the Commission with these duties.

In 1997, the Texas Statutory Probate Judges appointed the Guardianship Advisory Board which consists of eleven members representing each health and human services region. Subsequently, the Advisory Board has worked with the Commission to develop and implement an overall plan to expand guardianship services. The name, *"Guardianship Alliance of Texas"* was adopted to refer to the Commission's initiative to encourage growth of guardianship programs across the State.

Growth of Local Programs. To stimulate development and growth of local guardianship programs, the Commission distributed $52,000 in grant funds to five programs serving a total of eight counties. Three of these grants add guardianship and/or money management components to existing programs.

Money management services includes assistance with paying bills and serving as the representative payee to receive federal benefits. Overall, money management services are less expensive than guardianship programs and are less restrictive since rights are not removed by a court.

Needs Analysis. The Advisory Board used three approaches to obtain information about guardianship needs. Public hearings were held in four cities to give the public the opportunity to address guardianship issues with the Advisory Board.

A comprehensive survey was sent to 328 judges of county courts with guardianship jurisdiction. This survey was designed to collect data about the number of guardianship cases and the availability of local guardianship programs.

THE APPROACH

The third approach used was to estimate the number of people needing guardians based upon reports and projections of different populations such as the elderly, people with mental retardation, dementia, head injuries, mental illness, and people incarcerated. Also estimated was the number of people who do not have family members or friends to serve as guardians.

Public Education. Lack of funds to apply for guardianship is one of the most significant barriers faced by family members or friends interested in assuming these duties. To address this issue, the Advisory Board developed model policies to assist courts with implementing provisions of the Texas Probate Code. These provisions allow courts to initiate and pay for guardianship proceedings.

The *Guardianship Alliance* has made numerous presentations and distributed information about guardianship at conferences, seminars, and meetings involving judges, attorneys, and members of guardianship associations and programs.

TYPES OF LOCAL GUARDIANSHIP PROGRAMS

- County managed programs that use paid social workers to deliver guardianship services
- Private non-profit organizations that use paid social workers to deliver guardianship services
- Private non-profit organizations that use both paid social workers and volunteers to provide guardianship services
- Private non-profit organizations that primarily use volunteers to provide guardianship services

Guardianship Alliance of Texas

FACTS AND FIGURES

Current Facts:

- **Number of People Receiving Guardianship: 47,000**
- **Number of People Served by Local Guardianship and Alternative Programs: 2,400**
- **Number of People Receiving Guardianship Through TDPRS: 300**
- **Number of Guardianship Applications Filed in 1997: 5,000**
- **Number of Applications With No Family Member as Guardian: 900**

Projected Figures:

- **Number of People Who Need But Do Not Have Guardians: 45,000**
- **Number of People In Need of Public Guardianship Programs: 2,500**

THE RESULTS

How has this made a difference?

Need for Guardianship. The survey results compiled by the Advisory Board in 1998 indicate there are approximately 47,000 people receiving guardianship in the state. In 1997, more than 5,000 applications for guardianship were filed with the courts. In approximately 900 of these applications, there was not a family member to serve as guardian.

Of the existing 47,000 people with guardians, approximately 2,000 people are served by guardians provided through a local guardianship program and 400 people are supported by alternative programs. The state is responsible for guardianship for approximately 300 people which is provided by the Texas Department of Protective and Regulatory Services (TDPRS). Thus, only 5% of the existing guardians are provided through local or state programs.

The number of adults in Texas who have unmet guardianship needs almost mirrors the number of people who have guardians. The *Guardianship Alliance* conservatively estimates there are 45,000 adults today who need but do not have the assistance of guardians. This estimate includes approximately 15,000 people with mental retardation and 30,000 people who need guardianship due to dementia, closed head injuries, chronic mental illness, and stroke. Thus, approximately 45,000 people are potentially at risk of abuse, neglect, or exploitation and need assistance with decision making. These estimates are expected to increase dramatically in the first part of the 21st century due to growth of the population of people who are elderly and people with disabilities.

Of the 45,000 people needing guardians, the *Guardianship Alliance* estimates that there are over 2,500 people who do not have suitable family members or other individuals to serve as guardians. Thus, there are over 2,500 people in need of public guardianship programs.

Existing Guardianship Programs. The analysis by the Advisory Board in April, 1998, identified 15 separate guardianship and money management programs in Texas. Overall, these programs have annual budgets of $3.8 million and employ 106 paid staff and 578 volunteers to provide services to 2,763 people in 85 counties across the state. This includes:

THE RESULTS

- **Local Programs**: Primarily operating in larger Texas cities, there are 11 programs which are private non-profit entities, county funded programs, or private for-profit programs. A total of **2,021** people are served. These individuals do not have family members or other individuals able to serve as guardians. The average annual cost for services per person is **$1,233**. Seven of these programs include a money management component serving an additional **397** people.

- **Money Management Programs:** There are three additional programs serving **41** people that provide money management services independent of a local guardianship program. These services include assistance with paying bills and acting as representative payee for government benefits. These services are less restrictive and less expensive to operate than guardianship services. In total, there are **438** people receiving money management services at an average annual cost of **$917** per person.

- **TDPRS Program:** At the end of fiscal year 1998, this agency served as guardian for **317** people who are incapacitated and who have experienced abuse, neglect, or exploitation. In some cases though, courts appoint TDPRS as guardian when there are no other alternatives. In addition, there was a total of **145** pending guardianship cases. The average annual cost of services is **$2,208** per person which TDPRS pays for out of appropriations for other services.

The costs of guardianship services provided by local programs, particularly money management assistance, appear to be lower than the costs of state operated programs.

Expansion of Local Programs: To address the growing need for public guardianship, the Commission stimulated the expansion of three local programs and created two new programs through grants made in 1998. This local expansion will provide guardians for 75 people and money management services to an additional 70 people at a cost of less than **$700** in state funds per person.

To demonstrate how the state investment in a local program was maximized, described next is a **CASE IN POINT...**

CURRENT EXPENDITURES FOR GUARDIANSHIP

Health and Human Services Commission: $134,000 annually to support efforts to meet legislative mandates and to facilitate growth of local volunteer guardianship programs through grants.

Texas Department of Protective and Regulatory Services: No budget line item for guardianship services but over **$1 million** spent in 1997 by diverting resources from appropriations for other services to provide guardianship.

Local Guardianship Programs: $2.9 million spent in 1997; $1.88 million from county treasuries, $315,000 from contracts with TDPRS, and $720,000 from foundations, local funds and other sources.

Guardianship Alliance of Texas

CHECKLIST OF ACCOMPLISHMENTS

- ✔ Statewide needs analysis completed
- ✔ Existing programs studied and costs analyzed
- ✔ Minimum standards for guardians and guardianship programs identified
- ✔ Local guardianship programs expanded through grants
- ✔ Public education activities conducted
- ✔ Cost effective plan for increasing local guardianship programs developed
- ✔ Report to the Governor and 75th Legislature submitted

THE RESULTS

The Commission granted $15,000 in 1998 to Travis County's Family Eldercare Program to expand local guardianship services to Williamson County. Family Eldercare then obtained a $30,000 grant from Victims of Crimes Act to match these funds. At least 30 people were to receive guardianship services during the first year, but due to contributions by Williamson County, the capacity of the program is already expanding.

Williamson County agreed to waive filing fees, pay attorney ad litem fees, and authorize other fees from guardianship estates. Additionally, volunteer attorneys are being recruited to file guardianship applications for family members of persons who are indigent. This will allow the program to serve at least an additional 20 people.

Therefore, with collaboration between a local guardianship program and a county, and with $15,000 in State funds generating an additional $30,000, the program will provide 50 guardianship appointments reducing the State's cost to $300 per person.

Survey results indicate that only 17 of 254 counties are served by local guardianship programs. No local programs exist in three of the eleven health and human services regions. Judges are then faced with the problem of having nobody to appoint when a person needing a guardian is brought to the attention of the court and no family member is available. The courts often appoint TDPRS in these situations as the last resort. More local programs are needed and lack of funding is the biggest barrier.

Guardianship Standards. The Advisory Board developed minimum standards for guardianship programs and a code of ethics for guardians. The Commission endorses these standards. Applying such standards will help ensure that quality services are provided throughout the different programs.

Guardianship Plan. Based upon the analysis of the existing system of guardianship services and the present and growing demand for services, the Advisory Board determined that the most cost efficient alternative is to develop and expand local programs. Subsequently, a comprehensive plan was submitted to the Governor and 75th Legislature in December, 1998. Details of this plan are described in the following pages.

WHERE DO WE GO FROM HERE?

☆ ***With existing appropriations,*** the *Guardianship Alliance* will grant $60,000 in 1999 to develop or expand local guardianship programs to provide an additional 84 people with guardianships and 80 people with money management services.

☆ ***Minimum standards***, if adopted statewide, would apply uniformly to all guardianship programs and to volunteers or paid professionals serving as guardians.

☆ ***The Guardianship Plan will be implemented***, assuming Legislative support and funding. The Commission, the Advisory Board, and the Texas Department of Protective and Regulatory Services (TDPRS) propose to work together to implement a transition plan to increase the capacity of counties to provide guardianships while stabilizing the growth of the TDPRS guardianship program.

A six-year period is needed to achieve this transition from state-funded guardianships provided by state employees to local programs utilizing volunteers and professionals. This approach will provide a system for public guardianship services without creating reliance upon a state agency. Further, this approach will maximize the use of resources and allow counties flexibility in the design and operation of guardianship programs.

The Advisory Board proposes that the *Guardian Alliance* continue at the Commission and receive additional funding to encourage the growth and expansion of local guardianship programs.

As an exceptional item in the agency appropriations request, TDPRS has requested funds to maintain existing guardianship responsibilities and to allow for expansion to provide guardianship services to approximately 500 people.

The investment of funds to implement the guardianship plan would result in guardianships for approximately **4,200** people and money management services for **4,000** people. This would address the current backlog of 2,400 people in need of public guardianship services plus allow for at least 300 new guardianships per year.

Over this six year period, it is estimated that through partial reimbursement to counties for courts costs and grants to local programs to

SIX STEP PLAN TO FOSTER LOCAL GUARDIANSHIP PROGRAMS

1. Expand existing local guardianship programs into full service programs.
2. Encourage existing full service programs to offer services to nearby counties.
3. Focus on establishing local programs in counties where judges or TDPRS have identified the need.
4. Encourage counties to financially support local guardianship programs.
5. Encourage courts to use existing Texas Probate Code provisions (TPC 683) to initiate guardianships.
6. Use established local guardianship programs and the Texas Guardianship Association as educational resources.

Guardianship Alliance of Texas

TO-DO LIST

- Develop and expand local guardianship programs
- Obtain approval to implement the Guardianship Plan
- Implement minimum standards for guardians and guardianship programs
- Provide technical assistance and support to existing local guardianship programs as needed
- Address needed changes in the Texas Probate Code

WHERE DO WE GO FROM HERE?

pay portions of legal costs for low-income families, an additional **22,000** people would receive needed guardianships.

TDPRS will work with the *Guardianship Alliance* to target areas most in need of local guardianship programs. Local programs will be encouraged to match funds and resources. During the transition period of expanding local programs, the Advisory Board will examine the options for a state administrative structure to fund and provide oversight for local guardianship programs.

This plan would address the needs of many Texans for guardianship services which would primarily be delivered through local programs.

☆ ***Texas Probate Code changes*** have been recommended to the Legislature. Fourteen possible amendments are identified to allow greater flexibility to courts, to develop a new classification of "interim guardian", and to address other barriers that impact delivery of guardianship services.

☆ ***Other Legislative recommendations*** may be considered. The Advisory Board recommends that local guardianship programs have access to criminal record checks for staff and volunteers. Under current legislation, grants from the *Guardianship Alliance* may only be provided to volunteer programs. The Advisory Board also recommends that legislation be changed to permit grants to additional types of guardianship programs.

THE CHALLENGE

Why is it that a six year old child has lived in a nursing facility for the last three years?

It is well recognized and accepted that children belong with families. All children need the nurturing and care from loving adults with whom an enduring attachment is formed and maintained. Without such nurturing and care from families, children may not grow and develop, physically and emotionally, to the greatest extent possible.

Children may have significant medical, physical, behavioral, and/or emotional needs which challenge the abilities of families to provide the necessary care and support within their homes. Some children may have disabilities due to physical or mental conditions that necessitate that a range of services and supports be available and that parents learn and use special skills and techniques.

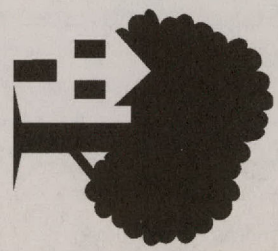
For example, children considered to be medically fragile may need the use of medical equipment such as ventilators and feeding tubes, special positioning to prevent deformities, medications given several times a day, and stimulation activities to facilitate learning of skills. Family members must take on the role of nurse, physical therapist, pharmacist, and teacher. Without assistance, families may be overwhelmed by these responsibilities as they try to work and provide for other family members.

Some families find themselves in the position of seeking placement of their child outside of the home. Families in this situation often feel that they have exhausted all other possibilities and placement is the only alternative. Attempts to obtain other services and supports to meet their needs may have failed.

Children with disabilities may be placed in institutional settings such as nursing facilities, state schools, residential facilities, or other residential arrangements. These placements often become long-term, indeed life-long for some children.

Placement outside of the home disrupts the attachment that children have with families. Institutional care-givers are not a substitute for the bonding, nurturing, and long-lasting attachment that families provide to children. A child's lack of attachment to a caring adult may have detrimental long range effects on growth and development.

It is estimated that there are approximately 680 children with disabilities in Texas living in out-of-home placements. Many barriers may be encountered in returning children to families and reconstructing or developing relationships.



Children with Disabilities

For information, contact:

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The following report is available:

Permanency Planning for Children in Texas, Report to the Texas Legislature (1998)

THE CHALLENGE

Here is a **CASE IN POINT...**

Bobby, a six year old child, has lived in a nursing facility the last three years. Bobby did live at home with his mom, dad and older sister. Bobby has profound mental retardation and complex medical problems including uncontrolled seizures, breathing difficulties, and frequent bouts of pneumonia related to aspiration. He is totally dependent on others for all of his needs and requires close supervision.

When he lived at home, Bobby's mother cared for him throughout the day and night. She had some assistance from other family members who would periodically relieve her. Also, a home health agency would provide nursing a few hours a day. Bobby has been hospitalized numerous times for various problems.

Bobby's mother developed cancer which necessitated long-term treatment. As a consequence, she was too ill to provide the care he needed at home. Bobby's dad had to work during the day as did other family members. The family could not find a program to provide the level of support they needed to continue to care for Bobby at home. Because they were in a crisis situation, the family placed Bobby in a nursing facility that is 300 miles from their home. This distance makes it difficult for the family to visit Bobby.

The health of Bobby's mother has improved. She would like him to come back home to live but is afraid that she will not be able to physically care for him. He now has a gastrostomy (feeding tube) and must receive feedings every few hours with special equipment. She also is concerned that his health may deteriorate without the daily medical care he receives in the nursing facility. Bobby continues living in the nursing facility and the ties to his family lessen over the years.

As the example illustrates, families in these situations may need services and supports from multiple programs. Effective planning and coordination is necessary to avoid costly out-of-home placements or to reconnect children with families. Without this, children may not have what they need the most — to live with a caring family. When it is not possible for children to live with their natural families, other family settings such as foster or adoptive homes may be options.

THE APPROACH

What is happening to address this problem?

State Policy. Recognizing the importance of families in the lives of children, the 75th Legislature adopted the following policy to guide delivery of services. *"It is the policy of the state to strive to ensure that the basic needs for safety, security, and stability are met for each child in Texas. A successful family is the most efficient and effective way to meet those needs. The state and local communities must work together to provide encouragement and support for well-functioning families and ensure that each child receives the benefits of being a part of a successful permanent family as soon as possible."*

Permanency Planning. Permanency planning is a service delivery approach now used by health and human services agencies to implement the state policy. Agencies have defined permanency planning as a process undertaken by public and private agencies on behalf of children with disabilities who are at risk of placement or in placement with the specific goal of securing a permanent living arrangement that enhances the child's growth and development.

Permanency planning is directed toward securing:

1. A consistent, nurturing environment;
2. An enduring, positive adult relationship;
3. A specific person who will be an advocate for the child into adulthood.

Legislation requires the Commission and each appropriate health and human services agency to develop procedures to ensure that a permanency plan is developed for each child residing in an institution, or for whom institutional care is sought.

Demonstrating Permanency Planning. Legislation also requires the Commission to implement local sites to coordinate permanency planning. Through grant funds provided to the Commission by the Texas Planning Council for Developmental Disabilities, four local family support collaborative sites have been established. This initiative is referred to as the *Families are Valued* project.

This project focuses on implementing statewide system changes to decrease the number of out-of-home placements for children with disabilities by incorporating the philosophy of permanency planning.

AGENCIES INVOLVED IN PERMANENCY PLANNING

- Texas Health and Human Services Commission
- Texas Department of Mental Health and Mental Retardation
- Texas Department of Protective and Regulatory Services
- Texas Department of Human Services
- Texas Interagency Council on Early Childhood Intervention
- Texas Department of Health
- Texas Commission for the Blind
- Texas Education Agency

Children with Disabilities

Related Legislation in the Government Code:

531.151 - 531.155 Permanency Planning: Includes a policy statement; requires the Commission and appropriate agencies to develop procedures regarding permanency planning; directs the Commission to implement local permanency planning sites and an agency reporting system concerning permanency planning.

532.112 - Children with Special Health Care Needs: Directs the Commission, in cooperation with the Texas Department of Health, to undertake initiatives to develop and implement methods for delivery of cost-effective health care services under managed care for children with special health care needs.

Related Legislation in the Health and Safety Code:

35.014 - 35.018 Care of Medically Fragile Children: Includes a policy statement; requires the Texas Department of Health Board to establish a pilot program to study the health care, maintenance, education, and social needs of medically fragile children and their families; and directs that a report be submitted about the program to the Sunset Advisory Commission by February 1, 2000.

THE APPROACH

The four sites participating in the initiative are:

- Austin Travis County MHMR Services
- Central Gulf State Operated Community MHMR Services
- Life Management Center of El Paso
- Uniting Parents of Amarillo

These sites are building family-focused and community based strategies to develop a system for coordinated service planning with children at risk or in out-of-home placement. Lessons learned from these sites will be used to identify needed system changes to further support children and their families in home environments within the community.

In addition to these four sites, the Commission is working with other state health and human services agencies to develop statewide policies and practices to implement the principles of permanency planning for children with disabilities.

Medically Fragile Children Initiative. In response to the growing need for a comprehensive and cost-effective community based services for medically fragile children and their families, the 75th Legislature directed the Texas Department of Health to establish a pilot program. The purpose of this pilot is to study the unique health care, education, rehabilitation, and social needs of medically fragile children and their families.

The Texas Department of Health contracts with the Commission to facilitate and oversee the implementation of this initiative. The pilot site is located in Abilene and is operated by the program, *The House That Kerry Built.*

The House That Kerry Built provides a variety of support services to assist medically fragile children and their families. These services include: medically supervised day care, in-home nursing, respite, specialized case management, parent mentoring, support groups, and a resource library. The program will test the impact of these services on children and families and identify potential cost-savings to the state.

Children with Special Health Care Needs Initiative. The 75th Legislature directed the Commission, in cooperation with the Texas Department of Health, to pilot methods to provide quality systems of managed care for children with special health care needs. The Commission has applied for a grant from the Robert Wood Johnson Foundation to provide technical assistance in support of this initiative.

THE RESULTS

How has this made a difference?

Agency Practices. The Commission has worked with state agencies to develop policies, procedures, and activities to ensure permanency planning as a goal in service plans developed for children living outside a family setting.

Agencies have now included specific permanency planning provisions in departmental rules, policies, manuals and handbooks. Agency staff are participating in local Community Resource Coordination Group (CRCG) meetings held to develop service plans for children at risk of placement in a nursing facility. Highlights of other changes made to implement permanency planning include:

❖ *The Texas Department of Mental Health and Mental Retardation has included permanency planning requirements in performance contracts with local mental retardation authorities. The Texas Interagency Council on Early Childhood Intervention now monitors permanency planning efforts of local programs.*

❖ *The Texas Department of Protective and Regulatory Services is working to deinstitutionalize children living in nursing facilities; placement of children in nursing facilities is now restricted. Texas Department of Human Services requires nursing facilities to notify the local CRCG when a child is placed.*

❖ *The Texas Department of Health has incorporated permanency planning principles into the Medicaid managed care process for children with special health care needs.*

"No Place Like Home" Curriculum. Through the *Families are Valued* initiative, the Commission developed a curriculum to provide training on state-of-the-art permanency planning methods to serve children with disabilities. The *No Place Like Home* curriculum is intended for educational and service planning uses, as well as a tool to train others.

The *Families are Valued* initiative has recruited and trained individuals across the state to be qualified instructors with this curriculum. To ensure consistent implementation of permanency planning throughout the programs, state agency staff have received this training. Parents, providers, local organizations, and individuals with disabilities have also been trained.

Family Collaborative Sites. The Commission provides leadership and coordination to the four sites implementing permanency planning for children with disabilities within their community. While the sites have been operational for only 18 months, important development activities have occurred.

CHECKLIST OF ACCOMPLISHMENTS

- ✔ More children with disabilities receive needed services and supports
- ✔ Fewer children placed in institutional settings
- ✔ Common definition and principles of permanency planning adopted by agencies
- ✔ State agency practices revised to incorporate permanency planning
- ✔ Statewide training curriculum implemented
- ✔ Family collaborative sites underway
- ✔ Program to study needs of medically fragile children begun
- ✔ Technical assistance provided to local sites on an ongoing basis
- ✔ Legislative report, *Permanency Planning for Children in Texas*, submitted 12/98
- ✔ Definition of children with complex special health care needs developed

Children with Disabilities

SUCCESSES OF FAMILY COLLABORATIVE SITES

Service delivery methods which are family-focused and community-based have been implemented. Examples include:

- "Wrap-around" approach to developing plans for services and supports with participation of families;
- Community review process initiated for children referred for placement;
- Parents assisting with community development and providing peer-to-peer support to families;
- Parents providing independent case management; and
- Public awareness campaign to reach out to parents of children with disabilities.

THE RESULTS

- Local ***community coalitions*** of agencies and organizations responsible for providing services to children with disabilities have formed to identify existing strengths and barriers within the current service system and implement plans to promote community living and inclusion.
- An innovative ***assessment tool*** for children with disabilities was developed to assist communities in identifying system strengths and gaps at the local level. The tool is also used to coordinate and monitor services and supports provided to individual children and families. The assessment tool is the first of its kind in the nation.
- Current resources spent on children with disabilities are studied in order to identify strategies to ***combine or "blend" funding*** sources to provide services and supports to more children within family settings.

By using the permanency planning approach, these local sites are providing services and supports that families need to keep children in home settings.

Medically Fragile Children. While the four family collaborative sites are coordinating existing services and supports within their communities, the *House That Kerry Built* program is providing specialized services to medically fragile children living at home with families.

Services like medically supervised day care and respite, as well as in-home nursing care are assisting families in important ways.

These services have positively impacted families in that many have become employed, or continued employment and the overall stress experienced by families has been reduced. It also appears that the health of medically fragile children involved in the program has improved in that there is a significant reduction in hospital expenditures.

Children with Special Health Care Needs. A definition of children with special health care needs has been developed. Plans are underway to identify a pilot site to test methods for reliably identifying and tracking children, using this definition as well as monitoring delivery of services provided through managed care.

In summary, these approaches are making a difference in the lives of children with disabilities and families. System changes at state and local levels have begun to decrease the number of out-of-home placements. Additional work remains to be done to further build a system to ensure that children and their families are supported and strengthened.

WHERE DO WE GO FROM HERE?

☆ ***Additional options for community-based services*** may be available to children with disabilities, assuming Legislative approval for agency funding requests. Several agencies have requested additional funds to further implement permanency planning by expanding family support services and Medicaid waiver programs.

☆ ***Efforts to move children from institutions*** into home environments will continue. Mechanisms for redirecting funding streams from institutions into community-based care will be examined. Children will be included in Project *CHOICE*, a special initiative the Commission has implemented to remove barriers to use community-based services for people seeking to return to community living from a nursing facility and those at risk of entering a nursing facility *(see page 48)*.

☆ ***Local permanency planning efforts*** will continue to be supported. The Commission will provide ongoing technical assistance to the four family collaborative sites and the site studying services to medically fragile children and their families.

Additional training will be provided concerning innovative service planning approaches like "wrap-around" and the assessment tool developed at one of the sites. The sites will further explore ways to blend and redirect funding streams that would allow additional children to be served in family settings.

☆ ***An initial evaluation*** of the local sites will be completed in 1999. This evaluation will assess the effectiveness of permanency planning methods and will analyze related cost data. The evaluation of the medically fragile program will assess the overall benefits to children and families and review cost savings. The evaluation results will guide future actions to better serve children with disabilities.

☆ ***Statewide efforts*** will focus on changing additional practices and policies to promote permanency planning. The Commission will work with appropriate state agencies to assess the effectiveness of current changes and to identify other needed efforts. Additional training using the *No Place Like Home* curriculum will be available to providers, administrators, policymakers, and families.

☆ ***A pilot for children with special health care needs*** will be implemented in 1999 to provide cost-effective quality health care under managed care plans. Quality of care standards applicable to this population will be developed. The Commission will publish a rule concerning classification of children with special health care needs after the pilot.

TO-DO LIST

- ✪ Seek additional options for community-based services
- ✪ Explore innovative funding approaches
- ✪ Continue technical assistance and support to local sites
- ✪ Conduct initial evaluation of local sites
- ✪ Include children in Project *CHOICE*
- ✪ Provide training statewide on strength-based approaches to service planning and delivery
- ✪ Identify other needed changes in agency policies and practices to support permanency planning
- ✪ Implement a pilot for children with special health care needs

CHILDREN'S SERVICES

- Community Resource Coordination Groups (CRCGs)
- Children's Financing Initiative

THE CHALLENGE

Who can help my son who has complex problems and seems to have "fallen through the cracks" of human services agencies?

There are children and adolescents in Texas whose complex needs present a significant challenge to the community services system. This could be a child, for example, who has mental health needs, has trouble in school, and been involved with the local juvenile probation system. Some of these children are at risk for placement outside of the home.

One of the difficulties posed for families is the fact that their child's complex needs can not be met by one agency or program. Frequently, attempts at accessing needed services fail. Many times these children do not meet the eligibility requirements for certain services because the "right" diagnosis has not been made or the child's behaviors are "not harmful enough". As a result, the child can be passed back and forth from agency to agency.

Health and human services are often an essential part of ensuring the physical, emotional, and mental well being of these children. Supports are needed for these children to develop into full and productive members of their community. If effective interventions do not occur early in the process, more costly and restrictive services may be needed in the future.

Here is a **CASE IN POINT...**

Jeff is fifteen years old, consistently runs away, and makes serious threats to his neighbors. The local juvenile probation department has been called several times. He has a long history of multiple and varied disabilities.

Until a few years ago, his mother literally tied Jeff to her with a rope. It was reported to child protective services that his parents used this method to prevent him from running away. Currently, Jeff's bedroom has plywood on his windows and iron bars on his door which is locked at night to safely contain him inside the house at night.

The family is receiving home-based services from the local mental health center in an effort to learn better ways to address Jeff's behavior. For the last three years, he has been absent, suspended and expelled frequently from school. Last year he received his education at home through an alternative program.

Jeff needs to be enrolled in public school and his family wants help with determining what measures are legally safe to contain their son. Jeff is at-risk for placement in a secure residential treatment facility if he continues to run away from home. Additional supports are needed to increase his chances of achieving success at school.

Community Resource Coordination Group

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Reports available include:

Making a Difference One At A Time, Fiscal Year 1996/97 Annual Report

Evaluation of the CRCGs of Texas: Phase 1 (1998)

THE CHALLENGE

As the example illustrates, supports and services from several agencies may be needed. A further problem is that there needs to be coordination amongst these agencies to provide comprehensive services that address all needs.

Staff from these agencies must work together with the family to implement a plan that maximizes available resources. Without such coordination, Jeff and children like him may "fall through the cracks" of the service system.

In 1987, the 70th Legislature responded to this problem by charging a state agency workgroup to develop a community based model to address children and youth who have multiple service needs.

A major challenge for this workgroup was to determine how to coordinate services, eliminate duplication, and share costs when needed. No additional funding was provided for this new initiative.

What resulted is a Memorandum of Understanding among various state agencies which outlines an approach for interagency coordination to serve this high risk population of children.

THE APPROACH

What is happening to address this problem?

Community Resource Coordination Groups (CRCGs). The model implemented by the agencies through the Memorandum of Understanding is called the *CRCG*. These CRCGs are local interagency teams composed of public and private agencies that come together on a case-by-case basis to develop plans for children and youth who have the most complex needs.

These groups are formed on a county-by-county basis. One group may serve a cluster of multiple counties or it may serve a single county. The members of the group are existing staff of various local agencies providing services to children and includes the participation of family members. A chairperson is chosen by the local members to facilitate staffings and coordinate activities. Staff participating in these groups do so in addition to their regular jobs.

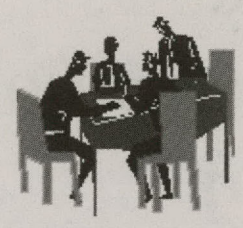
The CRCG serves children and youth under 22 years of age who need services that require interagency coordination. The model stresses the importance of family involvement in the process and of providing services in the most homelike and least restrictive environment possible. Members participating in the CRCG have the authority to commit resources and services of their agency.

Children and youth are referred to the CRCG by a participating agency that cannot provide or arrange all of the services that are needed. The CRCG meets with the family to discuss the specific problems and then develops a plan of action for coordination of services. This written plan of action includes:

- an identification of strengths and needs;
- services planned to meet those needs;
- additional assessments required;
- the agency responsible for each service;
- designation of the lead agency to provide overall coordination; and
- time frames for providing services, and monitoring and review of the plan.

Subsequently, the CRCG periodically reviews the implementation of the plan of action for the child. Plan revisions are then made as needed if desired outcomes have not been achieved.

Additional protocols have been put in place for children in certain circumstances to be referred by the CRCG. For example, the Texas Department of Mental Health and Mental Retardation has directed people to go through the local CRCG if they are interested in accessing services from the Vernon State Hospital and the Waco Center for Youth.



Partners in the CRCG Initiative:

- Health and Human Services Commission
- Texas Department of Human Services
- Texas Department of Protective and Regulatory Services
- Texas Department of Mental Health and Mental Retardation
- Texas Department of Health
- Texas Commission for the Blind
- Texas Rehabilitation Commission
- Texas Commission on Alcohol and Drug Abuse
- Texas Interagency Council on Early Childhood Intervention
- Texas Education Agency
- Texas Juvenile Probation Commission
- Texas Youth Commission
- Texas Workforce Commission
- Private Child-Serving Agencies
- Family Representatives

Community Resource Coordination Group

Related Legislation in the Texas Family Code:

Section 264.003 - Memorandum of Understanding: Requires various state agencies to adopt a memorandum of understanding to implement a system of local level interagency staffing groups to coordinate services for children and youth with multiple problems.

Related Legislation in the Health and Safety Code:

Section 242.802 - Notification Required: Requires that the CRCG be notified of institutional placement of children with developmental disabilities.

Section 242.803 - Offer of Services: The person making institutional placement may be contacted to ensure that family members of the child are aware of alternative services and supports, available placement options, and opportunities for permanency planning.

THE APPROACH

In addition, the 75th Legislature directed that CRCGs be notified and used as a potential mechanism for permanency planning for children at risk of nursing facility placement.

State CRCG Team. To direct the overall implementation of the CRCG model, a state level team of representatives from agencies participating in the Memorandum of Understanding is in place. Representatives from private service providers and parents are a part of this team as well. The state team is also responsible for addressing barriers that local CRCGs may encounter and for identifying gaps in services.

State CRCG Office. Created in 1993, this Office at the Commission is funded through resources provided by the state team. The State Office is responsible for assisting the state team to implement the CRCG model throughout the state. The State Office works closely with local CRCGs. To support the work of both the state team and the local CRCGs, the State Office concentrates efforts on providing technical assistance and collecting data to use for identifying strengths and needed improvements.

Technical Assistance. The State Office provides technical assistance to local CRCGs in several ways by:

- ➜ assisting communities to establish CRCGs;
- ➜ facilitating new CRCG training;
- ➜ distributing information and guidelines such as an annual report, an operational handbook, best practices;
- ➜ coordinating statewide and regional training conferences and workshops;
- ➜ coordinating support for particular CRCG case reviews; and
- ➜ serving as liaison between local CRCGs and the state team.

Data Collection. Local CRCGs voluntarily report data to the State Office concerning each individual who receives services. The data include demographic information, description of needs, agencies responsible for the service plan, unmet needs and barriers, and agencies participating in the team meeting. Data are analyzed each year to identify trends and recommend improvements to the CRCG process.

THE RESULTS

How has this made a difference?

Increases in CRCGs. After the initial pilot phase in a few local communities, a schedule for statewide implementation of CRCGs was developed in 1990. Counties serving the largest proportion of the state's children were initially targeted. Since 1990, the number of CRCGs has steadily grown and by 1996, all counties in Texas were served by a CRCG. The State Office was instrumental in assisting agencies to develop CRCGs within communities. Currently, there are **151 CRCGs serving all 254 counties**.

Children Served by CRCGs. The number of children and youth served by CRCGs has increased since 1990 as well. In 1997, over 800 individuals had interagency service plans developed through this process.

What are these children like? According to data analyzed by the State Office, for calendar year 1997, the majority of the children (63%) served are 13-16 years old and predominately Caucasian (62%). Most of these children were referred to the CRCG by the county juvenile probation department, local mental health provider, the independent school district, or child welfare. These figures reflect a trend that has been evident the past four years.

The most frequently reported needs that these individuals have include the following:

* residential treatment;
* family support and training;
* outpatient counseling;
* case management;
* educational services, and
* treatment for behavioral disorders.

Overall, the data indicate that CRCGs serve a high number of children with emotional disturbances who have multiple problems. Implementation of service plans developed by the CRCGs for each child have been effective. Six months after the initial plan was developed, 71% of the children had met all their plan goals. There were no barriers encountered in implementing the service plan for 60% of the children. Where barriers did exist, they were most often related to an unavailable service or to lack of family involvement.

Evaluation of CRCGs. The State Office plans a two phase evaluation of CRCGs. The first phase, completed in August 1998 by the University of Texas, addresses the overall operation of CRCGs. The second phase, to be completed by August 1999, will measure consumer satisfaction of families and children who have been served through the CRCG process.

What are the benefits of a CRCG?

These teams enable a community to provide better services to children by:

- improving coordination of services;
- preventing duplication of services;
- pooling resources;
- addressing the needs of the entire family;
- increasing knowledge about each agency's authority and services;
- identifying gaps in services at local and state levels;
- developing new or additional services in the community;
- planning jointly for needed services; and
- building better relationships.

Community Resource Coordination Group

CHECKLIST OF ACCOMPLISHMENTS

- ✔ Model for interagency coordination implemented
- ✔ CRCGs available for each county
- ✔ More children with complex problems receive needed services
- ✔ Fewer children "fall through the cracks" of the system
- ✔ Interagency planning has increased
- ✔ Gaps in services can be identified
- ✔ Technical assistance provided on an ongoing basis
- ✔ Numerous training conferences held
- ✔ Data collected and analyzed
- ✔ Evaluation of CRCGs, phase one, completed

THE RESULTS

How effective are CRCGs? The evaluation results indicate that overall the CRCGs are meeting the stated objectives of the Memorandum of Understanding. Approximately 75% of CRCG members surveyed report they are satisfied with the referrals made to the CRCG. Additionally, 75% report they are satisfied with how well the local CRCG meets the needs of children.

The primary strength of the CRCG process is the benefit of different professionals coming together to help an individual child. Resources are brought to the table and expertise is shared. The collective problem-solving of a team can make a tremendous difference in whether or not a child receives effective and timely services. Working together stimulates other collaborative efforts such as pursuing grant funds, figuring out how to pool funds and resources, and educating others about the work of CRCGs.

Local CRCGs report, however, there is a need for additional resources. A lack of funding for specific services such as residential treatment and substance abuse treatment is a problem noted. While some CRCGs have a full time coordinator, most do not. Also reported is the need to increase involvement of families in the process.

In summary, CRCGs are ***making a difference...one child at a time.*** Described below is a **CASE IN POINT...**

Mike is 16 years old and lives at home with his single mother. He is on probation for stealing and has been expelled from regular school classes and an alternative education program due to disruptive and aggressive behavior. He goes to the local library four hours a week for his education. He has a diagnosis of "emotional disturbance".

Mike was referred to the CRCG. One of the actions taken by the CRCG was to find a mentor for Mike who could be a positive male role model. A local church was contacted and Peter, who has a similar background, volunteered to be Mike's mentor. Peter worked with Mike throughout the summer and discovered he had a keen interest in football.

As the school year approached, Peter and Mike met with the school principal to ask that Mike be given another chance to re-enter school. The principal agreed for Mike to attend the alternative education program first with the understanding that if any problems occurred at school, Peter would be called.

With the support of Peter, Mike did not have any major problems at the alternative program and was allowed to return to regular classes. He was able to join the football team, became a star player, and finish high school.

WHERE DO WE GO FROM HERE?

☆ ***An independent consumer evaluation*** will be completed in 1999. This evaluation assesses the extent to which children and families are satisfied by the services and supports provided through the CRCG process. These results will help identify needed improvements in the process so that families and children are better served.

☆ ***CRCGs will continue to strengthen and expand*** operations. Indeed, CRCGs are recognized as effective planning mechanisms. It is expected that the demand for CRCG services will continue to grow. This poses additional challenges for local CRCGs that must struggle to find resources and operate in the most efficient way possible. Dedicated staff, a full-time service coordinator, and flexible resources could increase the number of children served.

A statewide CRCG summit was held in the fall of 1998 to collectively plan the strategic directions that are necessary to strengthen the work of CRCGs.

Six major objectives were identified for local CRCGs to prioritize and address over the next two years. The objectives include:

- Increase *public awareness* of CRCGs and education for families and the community.
- Increase *participation* of existing agencies and across a broader array of providers.
- Implement *strength-based approaches* including wrap-around.
- Develop and increase use of *informal supports*.
- *Educate* decision-makers about CRCGs, cost-effectiveness of wraparound and the need for resources to address the needs of children and families at the local level.
- Increase *prevention and early intervention* in the community.

The State Office will also explore additional ways to provide technical assistance and support to local CRCGs. Training on new approaches and best practices will be available.

☆ ***Expansion of the CRCG model*** to adult populations is being implemented. As with children, there are adults with complex needs that can not be addressed by a single agency.

TO-DO LIST

- ✪ Conduct independent consumer evaluation
- ✪ Seek additional resources for CRCGs
- ✪ Explore innovative funding approaches
- ✪ Provide training to CRCGs on new approaches and best practices
- ✪ Continue technical assistance and support to CRCGs
- ✪ Explore development and implementation of CRCG model for adult populations

Community Resource Coordination Group

EXAMPLES OF ADULT CRCG INITIATIVES

- **County programs** - two CRCGs have formed to address interagency needs of adults;
- **Alzheimer Project** - four sites are using an adult CRCG process focusing on people with Alzheimer's disease;
- **Dual Diagnosis Service Expansion Project** - nine sites are required to use a resource coordination group to address the needs of people who have mental health and substance abuse needs;
- **Plane State Jail Project** - site in Harris county is using the CRCG approach to reintegrate women back into the community from a state jail;
- **Guardianship** - one county is pursing the CRCG model to assist people in addressing guardianship related needs of adults.

WHERE DO WE GO FROM HERE?

Stimulated by the success of existing CRCGs for children, several communities are applying this approach to different adult populations, which have multiple needs and require services from several agencies. Statewide groups have also expressed interest in using this approach.

Subsequently, the State Office convened a group of state agency representatives to explore how to best coordinate efforts to support expanded implementation of an adult CRCG process. The following next steps are proposed:

1. ***State Team***: establish an ongoing team of agency representatives to develop, plan and coordinate implementation of an inclusive adult CRCG model that is applicable to different populations. In addition to the health and human services agencies, other involved agencies include: Texas Department of Criminal Justice; Texas Department of Housing and Community Affairs; Texas Workforce Commission; and the Texas Council on Offenders with Mental Illness.
2. ***Adult CRCG Coordinator***: identify resources to support staff to work with the State Office to facilitate implementation of the model through training, technical assistance, and consultation.
3. ***Model Sites***: test the proposed model in several communities.
4. ***Analyze Data***: collect data from the model sites to assess costs and feasibility of expanding to other locations.
5. ***State Level Coordination***: specify roles and responsibilities of participating agencies in implementing the model.

The State Office continues to work with agencies to explore the potential to implement these next steps to improve the quality and efficiency of service delivery to adults with complex needs who require services from multiple agencies.

THE CHALLENGE

Isn't there a better way to use the existing funds from different programs like juvenile justice, child welfare, and mental health to serve children and youth with severe emotional problems?

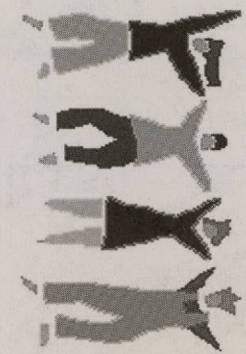
Today there are literally thousands of children and youth in Texas who need community-based mental health services. National data indicate that one out of every five children will need mental health services at some point before adulthood. It is further estimated that approximately 5-8% of all children and youth have severe emotional disturbances, and only one-third receive needed services.

Children with severe emotional disturbances require a range of mental health services available at varying levels of intensity. These children have multiple problems — problems at home, at school, and in the community. For example, some of these children may have been expelled from school, repeatedly run away from home, been involved in criminal activities, and have problems with alcohol and substance abuse.

As a result of these complex problems, children with severe emotional disturbances require intervention from other agencies and systems beyond mental health. The help that is needed typically does not neatly fall into one or more existing service categories.

A comprehensive system of care, with an array of mental health and other services and supports is required to meet the needs of children with complex and multiple problems. Services from special education, child welfare, health, alcohol and substance abuse, and juvenile justice programs are often needed.

The existing funding structure for public programs and services is fragmented and categorical. There have been numerous efforts involving agencies to improve services through collaboration and coordination. The *Community Resource Coordination Groups (CRCGs,* see page 71*)* are just one example of how existing resources can be coordinated at a local level for a particular child and used more effectively. However, to develop a complete system of care, with a full array of services that children and their families need, requires change that moves agencies beyond coordination and promotes blending or integrating their collective resources.



Children's Financing Initiative

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The following report is available:

Effectiveness of Intensive Community-Based Services (1999)

THE CHALLENGE

Children with severe emotional disturbances represent a small share of the entire population of children served. Yet a significant proportion of resources available are used by these children. In fact, the majority of mental health funds used by agencies are for high-cost residential and in-patient care. Significant juvenile justice or child protective services funds may also be expended. Further troubling, is the fact that little information is available about the overall effectiveness of various programs for these children.

Historically, there has been a tendency to remove children from their families and communities with the belief that effective treatment can best be provided in a residential setting. Community-based alternatives have often been neglected because there has not been an obvious financial incentive to serve children through a less restrictive, less expensive approach due to the categorical nature of existing funding streams.

An additional but critical problem with the current system is the expectation that children and families must conform to preexisting service configurations. To provide individualized services which are more likely to be effective, the system of care must be child-centered and family-focused so that the needs of the child and family dictate the types and mix of services provided. Furthermore, since parents are the primary caregivers, the system of care should support and assist families in this role and involve them in all decisions about services. Consequently, children will be more likely to remain connected with their families and intensive community-based services involving the child and family can reduce the need for costly out-of-home placements.

To illustrate these problems, here is a **CASE IN POINT...**

*On any given day, in Travis County alone there are **300 youth** with severe emotional problems who are in out-of-home placements. These placements are funded by the public child welfare, juvenile justice, education, local health and human services, and mental health systems. The annual cost for this service is approximately **$12 million**.*

*The average cost of residential services in Travis County is approximately **$32,000 per year** per child.*

THE APPROACH

What is happening to address this problem?

Texas Integrated Funding Initiative. Supported by funding through the Robert Wood Johnson Foundation and the Texas Department of Mental Health and Mental Retardation, the Commission has led the *Texas Integrated Funding Initiative* since 1996. The purpose of this initiative is to develop community-based systems of care for children with severe emotional problems. Community-based systems of care are family focused, accountable for outcomes and maximize all funding sources, including state, local and federal dollars.

This initiative is testing a new approach to providing services by using available funding in an innovative way. Funds from participating service systems are gathered or "integrated" into a single resource pool. The *Texas Integrated Funding Initiative* is based upon the following principles:

❶ Families are important and necessary partners in the development and implementation of an integrated service delivery system.

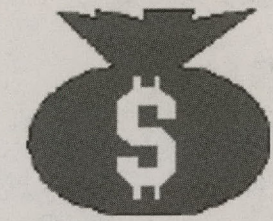
❷ Local control allows for better decision making, produces better outcomes at every level, and enhances community development.

❸ Managing funds and providers through a single local entity will produce a more accountable system of care with better overall outcomes for children and families.

Demonstrating Integrated Funding. The Commission supports local communities interested in this new approach by coordinating training and technical assistance. Currently, there are five communities that have received assistance with this initiative:

- Austin - Travis County
- Brownwood - Brown County
- Riceland region, south of Houston
- Dallas area
- El Paso

The Austin and Brownwood sites are fully operational and have identified their target population. The strengths and risks of children served in residential treatment were compared to a random sample of children receiving community-based services. This analysis indicated that there was a group of children and youth at both sites who had been placed in residential treatment, but who demonstrate a lower level of risk and could be successfully treated in the community.



STEPS FOR GETTING STARTED WITH INTEGRATED FUNDING

1. Identify target population
2. Collect and analyze data on target population
3. Identify existing funds available for target population
4. Collect historical cost information for target population
5. Assess current delivery system for target population with input from families and develop new approaches
6. Put local governance structure in place
7. Determine financial structures and incentives
8. Establish an interagency case rate for the target population
9. Train staff in new service delivery approaches
10. Develop an interagency evaluation and outcome tracking system

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Related Legislation:

House Bill 1, 75th Legislature, Rider 43: Directs the Texas Department of Mental Health and Mental Retardation to study the effectiveness of community based services options for children and families in decreasing the use of and/or length of stay in residential treatment.

Requires that costs, efficacy and benefits to children and families be evaluated in collaboration with the Health and Human Services Commission and the Texas Department of Protective and Regulatory Services.

THE APPROACH

These sites are developing community-based systems of care for the target population and are using new structures to integrate and manage resources. State-of-the-art treatment approaches to develop and implement individualized plans of care are utilized.

"Wrap-Around" Approach. Wrap-around is an approach designed to improve the lives of children and families with complex needs. The focus is on identifying what families really need, building on family strengths, utilizing both formal and informal supports and providing services that are flexible and individualized. This approach is to "wrap" services around what families need and to depart from the traditional categorical approach that "one size fits all". Staff at the sites are using this new approach with the target population.

Independent Care Coordinators. Both the Austin and Brownwood sites use care coordinators who function as generic case managers (*not tied to any one program or agency*) to facilitate the wrap-around process. The care coordinators work closely with a child and family team which not only includes professionals working with the family but also involves others close to the family such as friends, relatives, and faith leaders. Care coordinators perform the following functions:

- Identify, with the family, key players to be on the child and family team
- Perform a strengths discovery and assessment with the family
- Help the child and family team develop the individualized treatment plan
- Create and arrange services and supports, including non-traditional services
- Manage flexible dollars
- Evaluate services and supports

"Clinical Manager" Software. Staff at the sites have received special training and are now using an innovative software system obtained by the Commission. This software, *"Clinical Manager"* is designed to assist managers in tracking revenue and outcome data as well as assisting with care coordination activities. Use of this software provides the capacity to efficiently collect, maintain, and analyze data. This information will be the cornerstone of determining effectiveness of service and ultimately demonstrating accountability for outcomes and resources.

THE RESULTS

How has this made a difference?

Single Accountability and Management. Sites participating in the *Texas Integrated Funding Initiative* are responsible for determining an organizational structure to support planning and decision making for the system of care. The sites recognized that a new approach of integrated funding requires different structures which build on current interagency partnerships.

Rather than designating a lead agency to receive pooled funds, the Austin site created a new locally controlled non-profit agency. This non-profit agency consists of representatives from all of the participating agencies. This new agency provides a single structure for management and accountability. In Brownwood, the agencies developed a Memorandum of Understanding and an interagency oversight group to provide governance of the project. For both sites, governance responsibilities include: designating funds to the resource pool; developing the structure for purchasing and/or arranging services; determining the funding strategy; establishing shared outcomes of service; and ensuring family representation in planning and implementation.

Finance Structure. The flexibility of current funding streams was analyzed. Some agencies have been able to identify funds that can be used more flexibly. Each of the sites identified existing agency funds to contribute to a resource pool to support the delivery of services for the targeted population. An overarching principle used to guide this effort is the belief that dollars must follow children from high cost residential and in-patient care back to the community to pay for services that families want and need for children.

Administrative Service Organizations. To receive and manage the pooled funds from the participating agencies in a consolidated and independent fashion, each site has designated an Administrative Service Organization. Incorporating managed care concepts, the responsibilities of the Administrative Service Organization may include the following:

- Billing and fund management
- Development of rate setting methodology to refine the cost of service
- Care coordination activities based on individual service planning, involving the child and family
- Organization and management of a full array of services through a community-based provider network
- Measurement of functional outcomes of the provider network
- Utilization management activities which link clinical and fiscal aspects of care

KEYS TO SUCCESS FOR INTEGRATED FUNDING SITES

- *Pool funding* across child serving agencies to provide flexible and individualized services
- Create *one point of entry* into services to improve access
- Utilize a *wrap-around approach* to ensure individual treatment plans and improved outcomes
- Strengthen *family partnerships* within their community networks to improve overall quality
- Develop *independent care coordination* (case management) for seamless services
- Utilize *informal and formal supports* to assure children remain in the community
- Strengthen *family involvement* with their children in the treatment process
- Support community and neighborhood based providers to strengthen *cultural competence*
- Track financial, clinical, and outcome *data*
- *Evaluate* overall effectiveness and efficiency of services

Children's Financing Initiative

CHECKLIST OF ACCOMPLISHMENTS

- ✔ More children with complex problems receiving needed and appropriate services
- ✔ Less reliance on high cost residential services
- ✔ Support and "buy in" from all state level child-serving agencies
- ✔ Local sites operational
- ✔ Site staff trained on strength-based assessment and wrap-around
- ✔ Families integrally involved in planning and implementation
- ✔ Funds from child-serving agencies consolidated in integrated fund pool
- ✔ Structure for single accountability and management in place
- ✔ Case rate established
- ✔ Innovative approaches such as wrap-around and independent care coordinators used
- ✔ Software system used to track financial, clinical, and outcome data
- ✔ Technical assistance provided to local sites on an ongoing basis
- ✔ Federal grant obtained

THE RESULTS

Rate Setting Strategy. The Commission led the effort with state and local agencies to analyze historical cost data for children accessing intensive mental health treatment services. This is a critical activity to enable the local sites to ultimately determine a case rate. Data concerning 180 children were gathered across service systems which included child welfare, juvenile justice, mental health, education, and substance abuse. Data analyzed for each child included the services provided one year prior to residential treatment and for the first year of residential treatment.

An average monthly cost for services was calculated and adjustments were made to account for inflation and other factors. For the first time, use of a case rate allows the dollars to follow the child from residential into community-based services. Needed services and supports identified by the family and care coordinator can be paid out of the case rate.

Federal Grant. In the fall of 1998, the Commission received a $7 million grant from the federal Substance Abuse and Mental Health Services Administration that will benefit Travis County children and families. This grant was possible because of the work accomplished by the Travis County Children's Mental Health Partnership and the *Texas Integrated Funding Initiative.* Over the course of the next five years, this grant will further develop the local system of care with a special emphasis on providing additional supports and advocacy for families.

System Of Care. These sites have created new structures to operate a community-based system of care. The sites are demonstrating that better outcomes are achieved and resources are used more efficiently when they are integrated and jointly managed and when families are integrally involved in planning and implementing services. Here is a **CASE IN POINT...**

*In the past, if he were lucky enough to receive services, the only treatment option available to Carl, a 14 year-old with a history of psychiatric hospitalizations, would have been residential treatment. For six months, Carl has been setting fires and engaging in self-abusive behavior. For two months, he has not attended school. Now, instead of residential services, Carl and his family receive community-based services, including individual and family therapy, tutoring, and acute and crisis services. The outcomes have been good — Carl's support network of family and teachers remains intact, he is in school and plays in the school band, and he has not been hospitalized since his treatment plan was put in place. Furthermore, the cost of Carl's treatment has been significantly lower, costing **$10,300** a year for community services, rather than **$36,400** a year for residential services.*

WHERE DO WE GO FROM HERE?

☆ ***An independent evaluation*** will be completed in 1999. The 75th Legislature directed the Texas Department of Mental Health and Mental Retardation and the Commission to evaluate the effectiveness of intensive community-based services in decreasing the use of residential treatment. The local sites participating in the *Texas Integrated Funding Initiative* are the focus of the evaluation which will measure the following indicators:

- ★ Children and youth spend fewer days in funded residential care
- ★ Improved behavioral and emotional functioning
- ★ Improved school behaviors
- ★ Decreased involvement in the juvenile justice system
- ★ Decreased involvement in the child protective services system
- ★ Increased family involvement
- ★ Participant satisfaction

Because the sites have only recently begun to serve children and families, initial evaluation results will be available later in 1999. A legislative report detailing the outcomes of the local sites will be submitted in 2000.

☆ ***Existing local sites*** **will continue to strengthen and expand** operations. The Commission will continue to provide support and technical assistance, especially in the area of training. The Austin site has begun to implement activities related to their federal grant. The first year of grant activities focuses on laying the foundation for growth and expansion of the system of care. The Brownwood site is working on a goal of blending additional funding streams so that services are seamless from prevention to intensive treatment.

☆ ***Additional local sites*** will join the *Texas Integrated Funding Initiative.* Other communities have expressed interest in pursuing this approach. Supported by the federal grant, the Commission will provide technical assistance and training to these new sites, building upon the "lessons learned" from the existing sites.

☆ ***Statewide efforts*** will focus on providing training to child-serving state and local agency staff. This training will focus on best practices and include the wrap-around approach, development of effective individualized service plans, care coordination, interagency case review process, and cultural competency.

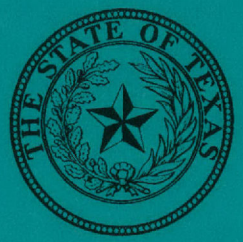
☆ ***The feasibility of applying the integrated funding approach to other populations*** will be examined. Use of this approach for children with developmental disabilities has begun (*see Children with Disabilities on pages 64-70*).

TO-DO LIST

- ✪ Conduct independent evaluation of local sites
- ✪ Continue technical assistance and support to local sites
- ✪ Assist additional communities interested in integrated funding and local systems of care
- ✪ Work with the Austin site to implement the federal grant
- ✪ Provide training statewide to state and local agency staff on new approaches and best practices
- ✪ Submit Legislative report concerning outcomes of the local sites in 2000
- ✪ Test the integrated funding approach with other populations

Acronyms

ACT	**A**gency **C**oordination **T**ask **F**orce
CHIP	**C**hildren's **H**ealth **I**nsurance **P**rogram
CIC	**C**ommunity **I**nformation **C**enter
CRCG	**C**ommunity **R**esource **C**oordination **G**roup
FAV	**F**amilies **A**re **V**alued Project
GAT	**G**uardianship **A**lliance of **T**exas
HHS	**h**ealth and **h**uman **s**ervices
I & R	**I**nformation **&** **R**eferral
LTSS	**L**ong-**T**erm **S**ervices and **S**upports
OCTS	**O**ffice of **C**ommunity **T**ransportation **S**ervices
CHOICE	**C**onsumers **H**ave **O**ptions for **I**ndependence in **C**ommunity **E**nvironments
TIES	**T**exas **I**ntegrated **E**nrollment and **S**ervices
TIFI	**T**exas **I**ntegrated **F**unding **I**nitiative
ECI	Texas Interagency Council on **E**arly **C**hildhood **I**ntervention
HHSC	Texas **H**ealth and **H**uman **S**ervices **C**ommission
TCADA	**T**exas **C**ommission on **A**lcohol and **D**rug **A**buse
TCB	**T**exas **C**ommission for the **B**lind
TCDHH	**T**exas **C**ommission for the **D**eaf and **H**ard of **H**earing
TDH	**T**exas **D**epartment of **H**ealth
TDHS	**T**exas **D**epartment of **H**uman **S**ervices
TDMHMR	**T**exas **D**epartment of **M**ental **H**ealth and **M**ental **R**etardation
TDoA	**T**exas **D**epartment **o**n **A**ging
TDPRS	**T**exas **D**epartment of **P**rotective and **R**egulatory **S**ervices
TEA	**T**exas **E**ducation **A**gency
TJPC	**T**exas **J**uvenile **P**robation **C**ommission
TPCDD	**T**exas **P**lanning **C**ouncil for **D**evelopmental **D**isabilities
TRC	**T**exas **R**ehabilitation **C**ommission
TWC	**T**exas **W**orkforce **C**ommission
TxDOT	**T**exas **D**epartment **o**f **T**ransportation
TYC	**T**exas **Y**outh **C**ommission



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